I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2013

State DUNS Number

Number
808886063

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
California Department of Mental Health

Organizational Unit
State Level Programs Administration

Mailing Address
1600 9th Street, Room 151

City
Sacramento

Zip Code
95814

II. Contact Person for the Grantee of the Block Grant

First Name
Cliff

Last Name
Allenby

Agency Name
California Department of Mental Health

Mailing Address
1600 9th Street, Suite 151

City
Sacramento

Zip Code
95814

Telephone
916-654-2309

Fax
916-654-3198

Email Address
cliff.allenby@dmh.ca.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
10/1/2010

To
9/30/2012

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name
John

Last Name
Lessley

Telephone
916-654-3535

Fax
916-654-2739

Email Address
john.lessley@dmh.ca.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that California agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	
Title	
Organization	

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

OVERVIEW OF THE STATE'S BEHAVIORAL HEALTH PREVENTION, EARLY IDENTIFICATION, TREATMENT AND RECOVERY SUPPORT SYSTEMS

Mission Statement

"The Department of Mental Health initiates, administers, supports and enhances an integrated, comprehensive system of public mental health services."

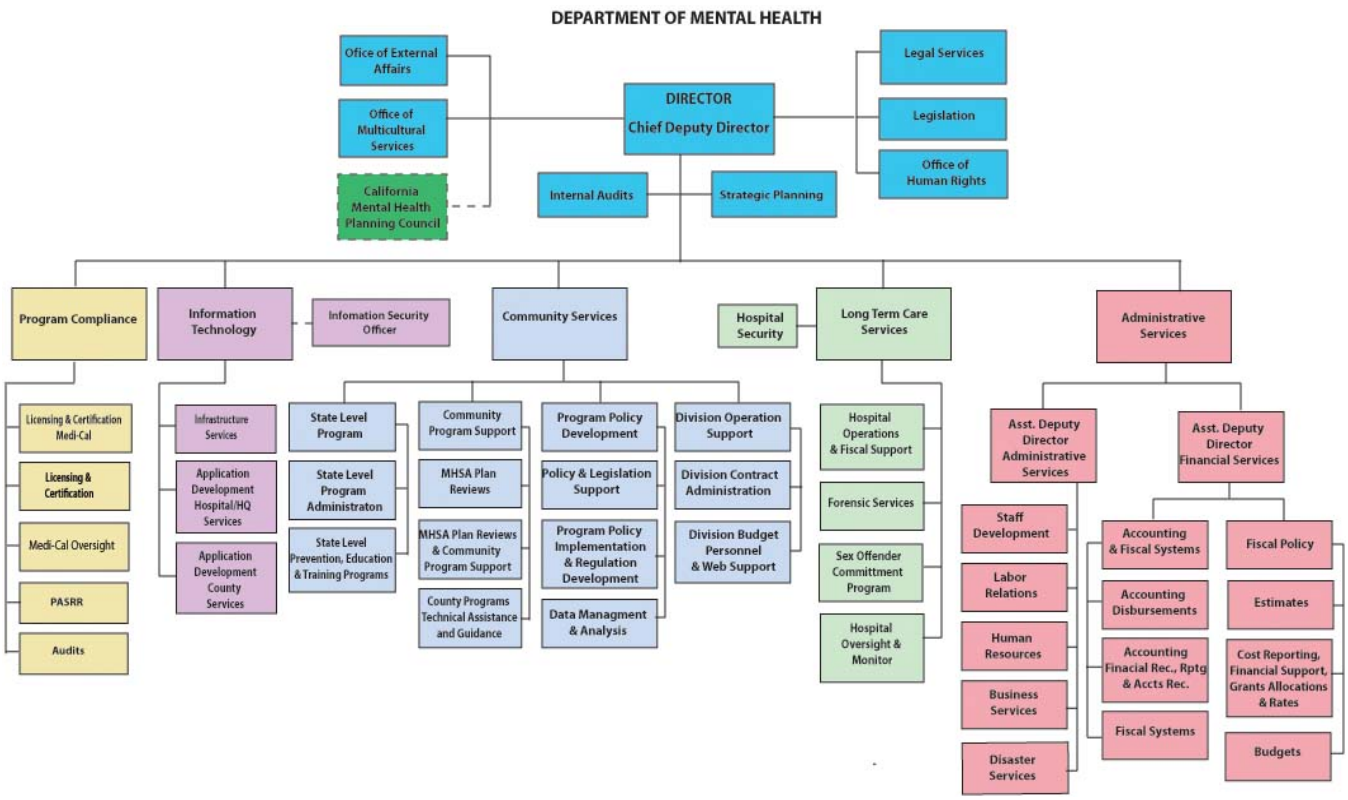
Organizational structure

DMH, headquartered in Sacramento, has oversight of a public mental health budget of approximately $5 billion, including local assistance and support funding. DMH employs approximately 12,000 employees at its headquarters office, five State Hospitals, and two forensic psychiatric programs managed with the California Department of Corrections and Rehabilitation.

As a state public agency, DMH has worked with mental health stakeholders to develop partnerships and coordinated interagency collaboration to transform and improve the state's public mental health system. These models have provided the framework for success in developing departmental programs and coordinating services in the treatment of children with serious emotional disturbances and adults who are experiencing severe mentally illness. All programs are designed with the recovery process as a core principle.

DMH's State Hospital programs have passed rigorous national accreditation reviews. Each hospital is staffed by professionally trained clinicians and an administrative support team who provide full-time inpatient care to the most serious mentally ill, as well as those incapable of living in the community. Referrals come from county mental health departments, the courts, the State Department of Corrections and Rehabilitation and the California Division of Juvenile Justice (formerly known as the California Youth Authority). In recent years, the population of the state mental hospitals has shifted to a majority (approximately 93 percent) of forensic patients, and DMH has met this challenge by prioritizing and balancing state-of-the-art treatment, employee safety and public security.

The DMH Director and Chief Deputy Director are appointed by the Governor of California. The DMH is organized into the following four major programs: Administrative Services; Program Compliance; Community Services; and Long Term Care Services. There are also the following support functions: Legal Services; Human Rights; Legislation; Office of External Affairs and Communication; Office of Multicultural Services; Internal Audits/Information Security/HIPAA and Office of Strategic Management. The DMH is currently undergoing a realignment restructure, which is detailed throughout the State Plan. The organizational chart below shows DMH's structure as of June 2011.



Public Mental Health System

California's public mental health system has evolved over the last four decades. This transition has changed the role of the State and local governments in providing care. Mental health services have moved from being predominately hospital-based and provided by the State, to community-based and provided through local governments.

Multiple State agencies provide health, mental health and related services. The primary department for ensuring the provision of mental health services is the California Department of Mental Health (DMH). It oversees county-based public mental health services, provides leadership on issues of policy and practice, and operates five State Hospitals and two correctional psychiatric programs. The primary public providers of mental health services are California's 57 county mental health departments (Sutter and Yuba counties combine their mental health plans) . DMH, State Hospitals, together with county mental health departments, provided services to a total of 631,863 individuals, in State Fiscal Year (SFY) 2009-10.

The Department of Health Care Services (DHCS) is California's single state agency for federal Medicaid, which supports and funds the treatment of Medi-Cal eligible clients. The Department of Alcohol and Drug Programs (ADP), Department of Housing and Community Development (CHCD), California Department of Corrections and Rehabilitation (CDCR) and multiple other State agencies offer services or coordinate programs available to mental health clients.

Mental Health Realignment

In 1991, State legislation was enacted to transfer fiscal and administrative responsibility for specified human services programs from State to local (county) authority. This Realignment provided a more stable funding base for local mental health programs, shifted program operation and accountability to the local level, and brought about many changes in State administration of mental health services. Realignment also strengthened the cooperative relationships between the State and counties. The State remained responsible for system oversight and integrity, and assisting the counties to effectively provide essential mental health services.

As a result of realignment, the DMH focuses its activities on these primary areas: community services, program compliance, and long-term care. State staff interfaces with counties through the provision of technical assistance and consultation.

Managed Mental Health Care

Over the past 15 years, there has been a move nationally to change the orientation of health care from the delivery of episodic treatment of illness to the planned provision of primary care, and other necessary services, in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed mental health care for California's Medi-Cal program is administered through a single managed care Mental Health Plan (MHP) in each county. California's managed mental health care program served 420,909 Medi-Cal eligible consumers in SFY 2009-10.

Each county in California has an MHP which contracts with DMH to provide Medi-Cal specialty mental health services. DMH is responsible for ensuring that local public mental health programs and their contract providers comply with State and federal laws and regulations for the Medi-Cal program.

Mental Health Services Act (MHSA)

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, has provided the opportunity for DMH to provide increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children, transition age youth, adults, older adults and families. The MHSA imposes a 1% income tax on personal income in excess of $1 million. Much of the funding has been provided to county mental health programs to fund programs consistent with their local plans.

An extensive stakeholder process was held to inform the state's implementation efforts. To provide for an orderly implementation of MHSA, DMH planned for sequential phases of development for each of the five components of the Act. The MHSA represents a comprehensive approach to the development of community-based mental health

services and supports for the residents of California. The MHSA addresses a broad continuum of prevention, early intervention and service needs. These include infrastructure, technology and training elements that will effectively support the local mental health system.

Two areas within the MHSA are discussed extensively later in this document: the Community Services and Supports (CSS) component, and, within that component, the Full Service Partnership (FSP) program:

- CSS is the largest component within the MHSA and provides funding to counties to expand or create programs designed to adhere to the principles of recovery- and strength-based community mental health treatment. CSS projects provide comprehensive adult and children's systems of care services to individuals that have a severe mental illness or serious emotional disturbance.
- FSPs are a wraparound program designed to provide comprehensive mental health services to individuals. FSPs provide all of the mental health services and other supports that an individual wants or needs to reach his or her goals, including transportation, counseling, peer support, financial assistance, and case management. In effect, FSPs operate on a "whatever it takes" model.

2011-2012 Redirection

DMH faces a redirection of resources to the local level in SFY 2011-12. The governor's SFY 2011-12 budget includes a plan to restructure how a wide range of services are delivered in California by further redirection of government functions and responsibilities from the state to the local level both in terms of decision making and budgetary authority. Realignment will be phased in beginning SFY 2011-12. Specific mental health programs and services identified for realignment are:

- Medi-Cal (California's Medicaid program) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) specialty mental health services for children and youth;
- Medi-Cal specialty mental health services for adults (known as "the Mental Health Managed Care Program"); and
- State-mandated mental health services for Special Education students, known as Assembly Bill (AB) 3632. Responsibility for "AB 3632" state-mandated mental health services for special education students, including out-of-home residential services, is transferred to school districts under the federal Individuals with Disabilities Education Act (IDEA) mandate..

Under realignment, funding in SFY 2011-12 only for these mental health services will be through a one time use of MHSA funds with an estimated state general fund savings of $861 million. Subsequent years may be funded through a reinstatement of the 1.15 percent Vehicle License Fee (VLF), and potential reinstatement of the 1% increase in sales taxes, if these taxes are approved by the Legislature and voters.

DMH Responsibilities in State Fiscal Year (SFY) 2011-2012

At the State level, the DMH is currently responsible for:

- Leadership;
- Administration of federal funds;
- System oversight, evaluation and monitoring;
- Direct services; and
- Administrative support.

Leadership

The primary role of the DMH is to provide statewide leadership to the public mental health system including planning, research, technical assistance, education, quality assurance, and program development of a broad array of initiatives for local services. Leadership activities include, but are not limited to:

- Implementing the State's mission and goals for mental health services;
- Advocating for quality mental health services for California's citizens with mental illness;
- Maximizing public and private financing opportunities (e.g. housing);
- Providing appropriate planning, research, technical assistance, training, and program development;
- Encouraging ongoing collaboration among clients, family members, providers and other members of the mental health constituency as well as interagency and cross-jurisdictional collaboration at the State level;
- Developing Suicide Prevention and Stigma Reduction plans;
- Workforce, Education and Training programs;
- Evaluates county MHPs for cultural competency measures and continuous improvement processes; and
- Supporting county implementation of the MHSA, which provides state income tax dollars for specific county mental health programs and services at the community level;
- Data collection and reporting and operation of the Early Mental Health Initiative (EMHI), which is a grant program funded by Proposition 98 education dollars.

Administration of Federal Funds

DMH is also responsible for securing and ensuring the continuation of federal funds. All tasks related to the administration of federal funds, such as utilization review, quality management, and cost reporting and settlement are included in this category. This includes the administration of federal funding for the following; Medi-Cal specialty mental health services and EPSDT; the Short Doyle/Medi-Cal (SD/MC) claims processing system; the annual Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant; the annual SAMHSA Data Infrastructure Grant

(DIG) technology grant; and the annual Projects for Assistance in Transition from Homelessness (PATH) formula grant.

System Oversight, Evaluation and Monitoring

DMH is responsible for oversight, evaluation and monitoring of public mental health services in California. The following DMH tasks related to oversight of programs or funds are included in this category:

- Research, evaluation and monitoring of performance outcomes, Medicaid compliance, and elements of the care for adults and older adults with serious mental illness, and for children with serious emotional disturbances;
- Negotiation of performance contracts and implementation plans with counties for the administration of local mental health programs;
- Licensing and certification of mental health clinics and facilities;
- Rate-setting;
- Assurance of, and monitoring of, patients' rights;
- Operation of the Ombudsman Office (see next page);
- Collection and reporting of county mental health data; and
- Oversight of the MHPs operated by county mental health departments.

Direct Services

DMH provides the following services either directly or through contract:

- Oversight of direct services provided through contracts with public or private entities, or with inter-governmental agreements;
- Direction and monitoring of programs for offenders with mental disabilities conditionally released into the community;
- Administration of programs and activities mandated by the State Legislature;
- Operation of the State Hospitals for individuals with mental disorders who have been placed either by counties in accordance with civil commitment statutes, or by courts or prisons in accordance with the State Penal Code;
- Operation of the Sexually Violent Predator (SVP) program; and
- Operation of programs in prisons for offenders with mental illness under contract with the California Department of Corrections and Rehabilitation.

Administrative Support

DMH also performs the administrative functions necessary to support its operations. These functions include:

- Personnel;
- Labor Relations;
- Financial Management;

- Accounting;
- Budgeting;
- Information Technology; and
- Public Administration.

In order to address service needs and oversee the mental health system as a whole, DMH has several offices and activities which enable surveillance of several critical mental health service user areas:

- DMH administers an Office of Human Rights to ensure that mental health laws, regulations, and policies for the rights of mental health service recipients are observed in State Hospitals and licensed health and community care facilities.
- To provide a direct contact, DMH administers a Medi-Cal Ombudsman office with a toll-free telephone line and email inbox to assist current Medi-Cal beneficiaries who need assistance navigating the mental health system.
- DMH is responsible for ensuring evaluation of individuals' needs for mental health services, and for placement in a nursing facility if an individual has, or is suspected to have, a mental disability.
- DMH is responsible for monitoring, certifying, and licensing of certain types of treatment programs (special treatment programs, psychiatric health facilities, community residential treatment systems, mental health rehabilitation centers, and community treatment facilities).

Ombudsman Office

The purpose of DMH's Ombudsman Office is to maintain a bridge between the mental health managed care system and beneficiaries receiving Medi-Cal. The Ombudsman's Office provides information and assistance to help beneficiaries navigate the system. There are several local resources, including the patients' rights advocate and MHP problem resolution staff, to which beneficiaries can turn for help.

Individuals who are receiving specialty mental health services or family or friends can contact the Ombudsman Office to ask questions or get referrals to appropriate resources for assistance. Persons assisting individuals can also call the Ombudsman toll-free telephone line to get information on Medi-Cal, legal advocacy and patients' rights resources.

External Quality Review Organization

The DMH has contracted with APS HealthCare to be its External Quality Review Organization (EQRO) to meet federal Medicaid requirements. The purpose of the EQRO is to objectively assess quality, outcomes, and timeliness of and access to the services provided by 57 California MHPs that contract with DMH to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals.

To assess the services of each MHP, the EQRO conducts annual external quality reviews that include:

- Assessment of DMH-specified Performance Measures (PMs);
- Assessment of MHP-selected Performance Improvement Projects (PIPs);
- Periodic evaluation of selected aspects of each MHP's on-going internal Quality Improvement (QI) system; and
- Review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program.

The EQRO prepares an annual report on each MHP to comprehensively assess the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The individual MHP reports utilize the EQRO's own assessment of each MHP in light of the review components described above. The EQRO also prepares an aggregate annual report for DMH based on the information gained in the assessments of the individual MHPs.

The EQRO provides up to four hours of technical assistance and consultation for each MHP annually. This is intended to meet the individualized quality improvement needs of each MHP and maximize the utility of the external review activity as a quality improvement learning experience.

Because of the unique nature of the Medi-Cal managed mental health care system, DMH calculates performance measures using claims data obtained from the MHPs. In order to fully assess MHP performance, the EQRO reviews various DMH data systems and processes in addition to the MHPs' system for reporting claims data. The EQRO prepares an annual report that comprehensively assesses the overall performance of DMH in this capacity.

The EQRO has utilized protocols for validation of performance measures and performance improvement projects and an information system assessment instrument developed by DMH, in addition to review protocols or instruments developed by the EQRO for use in other areas of the review. The EQRO has recently begun its seventh year of reviews with the focus of those reviews evolving over that period.

State Hospitals

DMH, through the Long Term Care Services (LTCS) Division, operates five State Hospitals that provide inpatient psychiatric care to nearly 5,000 individuals committed to the hospitals civilly or in connection with criminal proceedings. Two facilities are located in Southern California (Metropolitan State Hospital in Los Angeles County and Patton State Hospital in San Bernardino County), one facility is near the Central Coast (Atascadero State Hospital); one is in Northern California (Napa State Hospital); and a fifth facility (Coalinga State Hospital) in the Central Valley opened in September 2005.

The DMH State Hospital System mission is: *"Recovery Through Treatment, Rehabilitation, and Enrichment."* The DMH LTCS Division endeavors to support, teach, and treat individuals with serious mental illness, substance addiction disorders, and forensic issues in a safe environment, so that they can fully appreciate, manage, and overcome the nature and seriousness of their conditions, revive hope in their lives, and recognize their strengths and power to live productive and meaningful lives in their community. DMH LTCS is committed to implementing recovery-based psychosocial rehabilitation programs, maintaining the highest standards of care, and providing an atmosphere of creativity and continuous innovation. DMH believes that provision of services based on the principles of recovery through treatment, rehabilitation, and enrichment supported by technology, offers these individuals an effective way of achieving their rehabilitation and recovery goals.

Currently, approximately 93 percent of individuals in the State mental health facilities are forensic. This presents unique challenges to serve the more critical needs of these individuals. The mission of the LTCS Division was developed to direct the changes that have occurred and will continue as the hospitals evolve to meet the needs of this population.

The State psychiatric hospitals have been transformed to recovery-based services based on the assessed needs of the individual, the reduction of psychiatric symptoms and the increase of adaptive living skills. Individuals are given complete individual-centered and strength-based evaluations to guide treatment. Recovery focused assessments and reports are given to post-hospital care providers, for civil commitment recommendations to the courts and the Board of Prison Terms.

In addition, DMH is set to complete the Civil Rights of Institutionalized Persons Act (CRIPA) Consent Judgment in November of 2011. The extensive reforms required by the Consent Judgment will ensure that individuals in DMH's State psychiatric hospitals are adequately protected from harm and provided adequate services to support their recovery and mental health.

California Issues

The strength of California's mental health system lies in its goal of delivering culturally competent, client-directed recovery services with local advocacy and program implementation at the county level. California's mental health system maintains a strong commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight.

California has demonstrated that with effective treatment and support, recovery from mental illness is feasible for most people. California has developed effective models of providing services to children who are severely emotionally disturbed (SED), and adults and older adults with serious mental illness (SMI). These successful programs emphasize client-centered, family-focused, and community-based services that are

culturally and linguistically competent and are provided in an integrated services system.

The MHSA has provided an opportunity for California to transform its public mental health system. In that effort, DMH has moved in a deliberate, responsible and transparent process, seeking input in open meetings at the state and local levels. From that process, DMH has developed comprehensive guidelines to ensure that county plans correlate with what initiative designers and advocates want – a fundamental change in how mental health services are developed and delivered.

As of the date of this application, California is in the process of implementing a realignment design in which most major functions of the MHSA will be transferred to the county level. DMH will be responsible for administering a select group of statewide initiatives including: Suicide Prevention and Reducing Stigma and Discrimination, Housing, Multicultural Services, data collection and reporting. In addition, legislation was passed (AB 102) which moves DMH's major functions related to Medi-Cal to the California Department of Health Care Services. The intent of the state/local realignment is to bring the services "closer to the people;" it represents an unprecedented move away from centralized state administration and moves authority and responsibility to the counties, where each program and/or function can be individually tailored to the needs of each local community.

In SFY 2011-12, the Governor's budget directs that $861 million be redirected from county MHSA funds to pay for state mandated Medi-Cal EPSDT services, Medi-Cal specialty mental health services, and school mental health services. The DMH State MHSA Administrative fund was reduced from 5% to 3.5%, resulting in a reduction of 125 DMH positions and the discontinuation of ten Memoranda of Understanding (MOU) agreements with other State Departments that existed to implement MHSA goals and activities across multiple disciplines (e.g. social services, alcohol and drug prevention, etc.).

Since 2005, the MHSA has provided over $4.7 billion has been made available to counties, including funding for Community Services and Support (CSS) programs approved by DMH in collaboration with clients and family members, and reviewed by the Mental Health Services Oversight and Accountability Commission (MHSOAC). These programs are making a difference in the lives of tens of thousands of people, and include housing and support services for more than 20,000 homeless people with mental illness. Additionally, DMH spent only part of the money allocated in MHSA for administration, returning approximately $100 million to counties for services through June 30, 2009.

Although it varies from county to county, a relatively small percentage of clients can be fully served. A larger percentage of clients and their families receive some level of services, but are considered underserved. There also continue to be many individuals who may have SMI and children and youth who may have SED, and their families, who are currently not served. Many individuals who are homeless or incarcerated in jails or

juvenile halls fall into this latter category. Certain members of ethnic populations are also in this latter category and these ethnic disparities must be addressed.

Additional challenges with the adult and children's service have resulted from SFY 2011-12 budget actions to address California's historic budget deficit.

- Legislation directs one-time funding of $861.2 million from the Mental Health Services Fund (MHSA) for Early and Periodic Screening, Diagnosis and Treatment, Mental Health Managed Care and mental health services for students.

- Funding for the MHSA, which taxes personal income over $1 million, has continued to decline for the past few years due to the nationwide economic crisis. The majority of SFY 2011-12 MHSA funding will be redirected to General Fund for public mental health programs.

The strength of California's public mental health system is its ability to work collaboratively with local communities, the California Mental Health Directors Association (CMHDA) representing the 58 county mental health departments, the MHSOAC, the California Mental Health Planning Council (CMHPC), the California Mental Health Services Authority (CalMHSA), and other stakeholders. The vision is of a system that integrates MHSA into the larger mental health system and provides quality services to those in need, while ensuring accountability to the people of California.

SAMHSA Required Section: Bi-directional Integration of Behavioral Health and Primary Care Services

In 2008, the California Institute for Mental Health (CIMH) began the Integration Policy Initiative (IPI); a collaborative project with the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP). The IPI was funded by the California Endowment and IBHP. The project was developed to address the pressing need for improved linkages between the physical, mental and substance use healthcare systems serving California's safety net population. The goals were to:

1. Develop a set of policy recommendations to enhance the interface between behavioral health and primary physical health care.
2. Share the recommendations with local and state policy makers.
3. Accelerate systems (bi-directional) integration.

The vision of the IPI is "Overall health and Wellness is Embraced as a Shared Community Responsibility."

<u>Co-occurring Disorder And Client Record Sharing/Exchanges</u>

Presently, ADP is leading efforts to seek technical assistance from SAMHSA on confidential client record sharing across mental health and substance use disorders

systems of care for persons with co-occurring disorders. Similarly, the CMHDA and County Alcohol and Drug Program Administrators Association of California (CADPAAC) have requested training and technical assistance from SAMHSA independent of State Substance Abuse Authorities on data sharing across health care systems to address behavioral health and primary care in the new electronic era.

State Level Reorganization to Maximize Medi-Cal Efficiencies

Lastly, California has undertaken the start of a state reorganization of the California Departments of DHCS, DMH, and ADP. The proposed reorganization would eliminate DMH and ADP in an effort to transfer all state-level Medi-Cal responsibilities and functions to DHCS, including Drug Medi-Cal and Mental Health Managed Care. The current Administration sees many benefits for consumers, other stakeholders, counties and the State including an emphasis on bi-directional integration. Non Medi-Cal DMH and ADP programs, like SAMHSA and MHSA, would still continue in California. It is uncertain whether those programs would also shift to DHCS, or the remaining programs from DMH and ADP could be combined to form a new Department. The details of these transitions will be proposed in the January 2012 State Budget.

For consumers and stakeholders this state level reorganization:

- Improves the coordination, development and delivery of policies, programs and services for effectively dealing with co-occurring disorders.
- Improves access, providing a single point of contact and a stronger centralized voice for behavioral health policy and program coordination, development, implementation, and monitoring as well as problem resolution.
- Places California in a stronger position to advocate for greater parity of behavioral health with physical health.
- Improves outcomes and provides better quality assurance, accountability and focus on professionalism of the caregiver and provider community, and the counties that oversee them.
- Strengthens the platform and voice for the consumer and family member networks as this consolidation will provide them a significantly stronger centralized, coordinated platform for input into state and federal decisions regarding behavioral health program and policy coordination, development, implementation and monitoring.
- Supports the movement towards integrating access to “health care homes” offering comprehensive care management for Medi-Cal beneficiaries.
- Improves the ability to coordinate services for substance use disorders and mental health with those for other physical conditions, thereby improving patient care for co-occurring conditions.

For counties and the State this reorganization:

- Provides a stronger and more focused State interface with the federal government during communications regarding our waiver and state plan

amendments to appropriately integrate the rehabilitation, recovery, and resiliency model with existing federal requirements.

- Communicates a clear and consistent culture of accountability from the single state agency (as opposed to having the different cultures of DMH and ADP interpreting and implementing Medi-Cal policy, program development, implementation, monitoring, and sanctions differently).
- Supports health care reform and the integration of Substance Use Disorders with and mental health with primary care by consolidating these services in DHCS, the department responsible for primary care and overall health care delivery.
- Supports the federal government's effort to encourage integration of mental health and substance abuse care. The new guidelines for the SAMHSA block grant application require states to explain how they will address and integrate co-occurring disorders.
- Provides a coordinated approach to dealing with potential waste, fraud, and abuse of Medi-Cal funds, which will reduce duplication of functions, costs, and confusion.
- Improves alignment with many behavioral health administrative structures at the county level, as many California counties already function administratively with consolidated mental health and alcohol/drug programs.
- Provides counties with a significantly stronger single point of contact and therefore, a more effective and efficient avenue for their input into state and federal deliberations and decisions regarding behavioral health program and policy coordination, development, implementation, and monitoring.
- Increases administrative and operating efficiencies at the State level.
- Increases the State's ability to address the infrastructure components of health care reform including electronic health records, as well as complex billing and data collection and reporting systems.

Provision of Recovery Support Services for Individuals with Mental Illness or Substance Use Disorders

DMH has a long history of supporting recovery activities with mental health services and supports. Since the passage of the MHSA, this has become more specific in the development of counties' plans and DMH has emphasized recovery and wellness for all mental health services.

Clients and families have become integrated into the county planning processes and for input in some of the Medi-Cal activities such as program compliance reviews. Another way that DMH includes clients and family members is through a federal and state mandated advisory council. California has a long history of mental health advisory boards that represent and advocate for the interests of those served by the department, beginning in 1960 with the establishment of the Citizen's Advisory Council. The current entity, the CMHPC, was established in state statute in 1993 in response to the realignment of mental health program responsibility and funding. (CA Welfare and Institutions Code 5771 et seq.) The council operates independently from the DMH to

provide public input into mental health policy development and planning. In addition to establishing a dedicated funding base for mental health services, realignment provided county governments with greater autonomy and flexibility in managing their local mental health programs. The Planning Council was designed to be an appropriate structure for public input, planning, and evaluation under realigned mental health programs.

DMH Strategic Plan 2009-2014

DMH recently adopted an updated strategic plan for 2009-2014 which will carry the department through current changes and the upcoming effects of healthcare reform and state level reorganization. It emphasizes strength based wellness with the goals of: improving outcomes, enhancing public safety, investing in change, ensuring accountability, and empowering people. In 2011, DMH developed a business plan and reporting structure to measure its progress towards accomplishing specific operational objectives set forth in the strategic plan.

California Department of Alcohol and Drug Programs

ADP is committed to the development, maintenance, and continuous improvement of a comprehensive and integrated continuum of public alcohol and other drug (AOD) services system based on acknowledging both the acute and chronic nature of AOD problems and addiction. Fundamental to this system is the recognition that addiction causes problems that are of a continuous, chronic, and relapsing nature to both individuals and communities, necessitating ongoing care and support. Critical to this recognition is the negative impact of substance use disorders to other systems such as child welfare and foster care, criminal justice, mental health, and primary care; if substance use is not addressed.

Viewing substance dependence and addiction as a chronic disease has required a shift in thinking about current systems for addressing AOD problems to believing that a new integrated system of care is necessary in order to achieve the desired outcomes for the prevention, treatment, and recovery for those individuals and communities served by the AOD field. This new system of care requires integration and coordination from the many stakeholders in the AOD field working in prevention, treatment, and recovery support services, as well as partners in mental health, primary health care, law enforcement, social services, and education.

ADP continues to emphasize Continuum of Services System Re-Engineering (COSSR) in examining the current AOD services delivery system. The primary goal of the re-engineering process is to work with ADP's stakeholders to reshape and reposition ADP's operations to ensure system accountability, efficiency, and effectiveness, while delivering comprehensive, high-quality AOD services within the framework of a public system of services.

The Continuum of Services model contains the following elements:

- Intervention must occur at all levels in the continuum.
- Coordination of services within the AOD services model and with other service providers is a critical component of a successful system of care.
- All AOD services provided within the system should be sustainable, integrated, culturally competent, and evidence-based.

This recovery support services model formally acknowledges both the acute and chronic nature of AOD problems and addiction and represents a newer perspective of substance abuse, dependence and addiction as a chronic condition across systems.

Combined DMH / ADP Plan for Any Expenditure of Funds for Co-Occurring Disorder (COD) Services

California has separate and distinct systems of care for mental health and substance use disorders. However, many California counties structure both systems under a behavioral health organizational model. Even though some county mental health and alcohol and drug agencies remain separate, there is improved communication on COD services and funding. This is evidenced by the work of both entities, who emphasize the importance of COD clients and funding options through their committee work and advocacy for funding. It is also emphasized locally, where county financing options of these services continue to be researched, designed for the most effective use of funds, and organized around cost centers that attempt to improve efficiency.

The Co-Occurring Joint Action Council (COJAC) Funding Subcommittee is another example of efforts to increase opportunities to plan for and strategize ways to combine funding for COD services. Recently, the subcommittee released a COD services funding matrix that outlines all of the possibilities for potential funding, including but not limited to, Medi-Cal, State general fund categorical programs, federal funding including SAMHSA and Access to Recovery (ATR), and minor consent state-only Medi-Cal funding.

Likewise, DMH and ADP continue to seek ways to untangle funding pathways to integrated services so that counties and providers have an easier time “braiding” fund sources for integrated treatment, an extremely difficult task as California has a complex array of funding streams that come with specific requirements and not much flexibility. This is a result of varied policy choices and overlaying state legislative and federal priorities over time.

Going forward, DMH and ADP will continue to look for ways to combine funds where it is allowed by federal laws and regulations. Certainly, the planned integration of behavioral health with primary care under health care reform presents opportunities.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

Page 22 of the Application Guidance

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM

Professionals Shortage

California has also suffered from a significant shortage of public mental health workers with high vacancy rates exist in certain occupational classifications. There is a recognized lack of diversity in the workforce, poor geographic distribution of existing mental health workers, and under-representation of individuals with client and family member experience in the provision of services and supports. Particularly, severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, older adults and diverse ethnic/cultural populations heretofore unserved or underserved.

Minorities are underrepresented among mental health providers, researchers, administrators, policymakers, and consumer and family organizations. Furthermore, racial and ethnic minorities continue to be underrepresented, relative to their proportion of the U.S. population, within the core mental health professions; psychiatry, psychology, social work, counseling, and psychiatric nursing.

Under the MHSA Workforce Education and Training (WET) programs, DMH has contracted with agencies to address specific needs and disparities. DMH has a MOU with the state Office of Statewide Health Planning Department (OSHPD). As a part of that MOU, OSHPD has coordinated efforts with DMH to assist counties in accessing additional areas of revenue and support for solving professional shortages. Within the past four years, California has had 64 applications to Health Resources and Services Administration (HRSA) for mental health professional shortage areas approved, resulting in a total of 163 California communities being federally designated as mental health professional shortage areas. This is a 48 percent increase from SFY 08-09 to SFY 10-11.

Mental health professional shortage area designation provides the community designated access to federal benefits to increase mental health professionals in designated shortage areas. Benefits include student loan repayment, scholarships and scholar placement programs, visa waiver programs, bonuses to psychiatrists, and a drug discount program.

Additionally, under the MHSA WET component, county mental health departments are to include fundamental concepts and core values relative to cultural competence by developing and implementing recruitment, retention and promotion strategies to effectively address the needs of particular racial/ethnic, cultural, and /or linguistic populations or community being served. Due to current economic hardships and cut backs, the retention of multilingual and multicultural mental health service providers is a challenge. Furthermore, workforce strategies to create career pathways and educational stipends are limited.

Veterans, Service Members, and Families

DMH has supported multiple activities to better meet the mental health needs of veterans, service members, and their families. California is one of only three states that have a Veterans Network of Care website, it's located at http://networkofcare.org/index2.cfm?productid=17&stateid=6 . Since 2010 DMH has hosted a veteran's mental health website that provides current information about resources, services, and training. DMH oversees two MOU's with the California Department of Veterans Affairs and the California National Guard, using MHSA funding, to build a statewide infrastructure for information, assessment, and referral of mental health needs for veterans in California. Military culture training is also provided for public mental health providers to build the capacity of the mental health system to meet the needs. These are important steps, but unmet needs (as identified by the CMHPC) remain, including: better collaboration and linkage of state and local civilian services with the federal Veterans Health Administration services; more connection with family-centered mental health supports for family members; meeting the service needs of veterans that do not have access to federal VA services due to distance or who prefer not to use VA services, including development of reimbursement agreements between the federal VA and local mental health providers.

In 2010 DMH was one of ten states to participate in a SAMHSA sponsored Policy Academy that focused on service members, veterans, and their families. California developed a 2010 strategic plan as a result of this Academy, however due to Administration transition, budgetary and resource constraints, the plan has not been formally adopted.

Cultural Competency

The DMH Office of Multicultural Services (OMS) provides statewide leadership for promoting culturally and linguistically competent mental health services within the public mental health system. With the support of the Director, OMS works with community partners to coordinate the elimination of racial, ethnic, cultural and language disparities in access and quality of care within mental health programs and services. OMS works to foster change in policy, access, language, clinical practice, research, and intervention practices.

OMS attends and participates on several committees to address the needs of unserved, underserved and inappropriately served individuals. OMS has been successful in opening the dialogue with external stakeholders such as:

- California Mental Health Director's Association Ethnic Service Committee
- California Mental Health Director's Association Social Justice Advisory Committee
- California Institute for Mental Health Center for Multicultural Development
- Mental Health Services Oversight and Accountability Commission Cultural and Linguistic Competence Committee
- California Mental Health Planning Council Cultural Competence Committee

- Cultural Competence/Ethnic Services Managers
- State Workgroup to Eliminate Disparities; as well as other stakeholder initiatives

It is through these forums that OMS continues to hear from partners and stakeholders of existing barriers and obstacles that racial, ethnic and multicultural communities encounter when seeking mental health services. These committees also serve to inform the OMS of changes that need to be made to improve access, quality of care and outcomes for unserved, underserved, and inappropriately served communities.

A major component of cultural competence work within the DMH is the development of the Cultural Competence Plan (CCP) requirements. OMS ensures county compliance with California Code of Regulations (CCR), Title 9, Section 1810.410 (c) by reviewing and scoring 58 county CCPs. Each county is required by statute to create a CCP that assesses cultural competency needs and creates action steps to leverage support and resources to operationalize cultural competence system wide. These plans are reviewed and scored for compliance standards. Through this process, the OMS provides technical assistance and feedback to assist counties in being culturally responsive to the diverse groups that make up the demographics of the county.

OMS coordinates efforts to reduce disparities in access and quality of care for California's racial, ethnic, and cultural unserved and underserved communities. OMS works to foster change in policy, access, language, clinical practice, research, and intervention practices.

Reducing Disparities

Despite the advances that have come from implementation of the MHSA and its subsequent programs, California's public mental health system still faces major disparities in access to services for the underserved communities of California, which include both the indigent communities and communities of color, including Limited English Proficiency (LEP) individuals.

In the 2005 report titled *California Mental Health Master Plan: A Vision for California*, the CMHPC states that "a crisis also exists in access to mental health care for persons who are indigent…the availability of services for indigents has only gotten worse."

The report further states that "this unmet need for mental health services and crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wrap-around programs and strength-based, family-focused treatment planning, have brought breakthroughs in services to children and their families."

According to the University of California, Los Angeles (UCLA) Center for Health Policy Research, the *State of Health Insurance in California: Findings From the 2005 California*

Health Interview Survey (2007), 74% of California's uninsured are from communities of color.

According to the 2003 President's New Freedom Report: Achieving the Promise: Transforming Mental Health Care in America, "The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them." Consequently DMH continues to work with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial ethnic and cultural communities. Only through true partnership can progress be made to eliminate the disparities in mental health outcomes. California is one of the most demographically diverse states in the nation. California's population has grown by over 21 percent since 1990. Multicultural populations now comprise more than 51% of the State population according to the California Department of Finance Office of Demographics. The State's Hispanic/Latino population has grown by almost 50 percent, from 7.7 million in 1990 to over 14 million in 2010, followed by the Asian/Pacific Islander population, up over 61 percent to 3.7 million in the same time period. The Hispanic category includes all persons who indicated Hispanic or Latino in the 2010 Census. These changes make it imperative that mental health policies, services planning are designed with this growing diversity in mind.

<u>Underserved Latinos</u>

Latinos in California make up the largest in the nation at over 14 million strong (per 2010 census data) yet are continually and historically underserved in the public mental health system. The disparities lie in areas of access to care, appropriateness of care, and availability of care. According to a 2009 presentation conducted by the University California Davis Center for Reducing Disparities, since the 1980s, studies have shown that Latinos are more likely to:

- Delay or not seek mental health care;
- Receive less adequate care; and
- Terminate care earlier.

Additional data indicates Latino children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or a mental health setting. Latinos continue to have poor access to specialty mental health care and more likely to seek mental health services in the primary care setting. Stigma is a major obstacle to Latino help seeking behavior and underserved populations are significantly under-represented in mental health research.

Language capacity continues to be a large barrier to services:

- Spanish is a threshold language in 51 out of 58 California counties (a threshold language is defined as a primary language of 3,000 individuals or 5% of the population). Language access continues to be a major barrier to access and quality of mental health care.

Per the California External Quality Review Organization 2009-10 Statewide Report: In Medi-Cal, "Hispanic beneficiaries are underserved compared to those eligible" and in 38 of 58 counties, Hispanics are below the statewide cost per Hispanic (Medi-Cal) beneficiary. See Table 1 below of Summarized CAEQRO data.

Table 1

Calendar Year	Average Payment Per Beneficiary Served	
	Hispanic	Whites
05	$3,601	$4,178
06	$4,022	$4,481
07	$4,203	$4,544
08	$4,448	$4,621

Underserved and Inappropriately Served African Americans

Almost 2.3 million African Americans live in California, per 2010 census data. According to the African American Utilization Report 2011, "Most behavioral health care programs in California serve African Americans at a disproportionately higher rate than other ethnic communities, and these services are provided in extremely restrictive (often involuntary) settings such as hospitals and jails."

In Alameda County, the second largest African American population in California, "low income African Americans with serious mental illness (and co-occurring disorders) represent 25% of our population, yet receive 40% of all mental health services." Further disparities include the African-American penetration rate of 13.57% compared to Hispanics at 4.81%, and Asian Pacific Islanders at 4.18%.

In 2008, African Americans in California represented 10% of the Medi-Cal average monthly unduplicated eligibles yet were served at 16%, a disproportionately served community in California. Behavioral health care programs in California serve African Americans at a disproportionately higher rate than other ethnic communities. These services are provided in an extremely restrictive, often involuntary, setting such as hospitals and jails. According to DMH Medi-Cal paid claims data, the utilization rate by African American clients for 24-hour mental health services, which include psychiatric inpatient hospital services, was 14.8%.

To further illustrate the gap, one county's data indicates 33% African American transition age youth (TAY) are eligible for Medi-Cal yet virtually 50% of Medi-Cal clients are African American TAY.

Unserved, Underserved, and Inappropriately Served Native Americans

California is home to one of the largest tribal populations in the United States and reflects a broad number of tribes and tribal people who practice varying degrees of

native traditions and culture. Add the fact that California is home to over 100 federally recognized tribes, and it is easy to see that there is just not one approach to outreach and engage tribal communities in mental health care services today (Inter-Tribal Council of California, Native American Resource Directory). Nationally, there is approximately 562 federally recognized tribes, plus an unknown number of tribes that are not federally recognized. The population of American Indian/Alaska Natives (AI/AN) including those of more than one race, was estimated at 4.9 million, making up 1.6 percent of the total population as of July 1, 2008 according to the Census Bureau; this is projected to rise to 8.6 million, 2 percent of the total population, by the year 2050.

We are all aware of the disparity in health status, including mental health, within Native communities. There are many factors which influence the mental health and well-being of Native Americans across California. Depression, historical trauma, substance abuse, access to clinical counseling and lack of access to traditional healing practices are just a few of those factors.

In 2008, the Surgeon General reported increased risk for depression and substance abuse and stated that AI/AN are overrepresented among high-need populations for mental health services. The report states elevated rates of homelessness (8% versus 2%), substance abuse (70% versus 11-32%), and incarceration with 1 in every 25 AI/AN adults in the criminal justice system (USDHHS 2008).

The 2007 California Health Interview Survey, conducted by the University of California Los Angeles, showed 15.8% of adult AI/AN reported psychological distress in the past compared to 8.2% for non AI/AN, 2007 California Health Interview Survey (CHIS).

According to the Center for Disease Control and Prevention, in 2007, a total of 34,598 suicides occurred in the United States - 83.5% of the suicides were among Non-Hispanic whites, 7.1% among Hispanics, 5.5% among non-Hispanic blacks, 2.5% among Asian/Pacific Islanders, and 1.1% among American Indians/Alaska Natives. Suicide rates by race/ethnicity and age group demonstrated different patterns. Though the greatest percentage of suicides occurred among Hispanic whites, the highest race/ethnicity and age specific rates were among American Indian/Alaska Native adolescents and young adults. In each of the groups, suicide rates were higher for males than for females.

Per the Santa Clara CCP narrative, Native American consumer and family members that were served went from 0 in SFY 2009, in quarter one (Q1) to over 400 in 2010.

Table 2

SFY 09				**SFY 10**			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
0	**17**	**74**	**81**	**47**	**55**	**65**	**437**

Additionally, Santa Clara County's Foster Care data show the highest penetration rate among Native Americans at 83.33% and a shortage in cultural and linguistically competent staff to serve them. Their data and statistics show that: Native American youth make up 19.7% of school drop-outs while they comprise .3% of the county's 0 to 18 year-old population. The county has changed their TAY system of care and their Adult system of care models to incorporate more culturally sensitive referral systems, such as to those cultural specific agencies that serve mostly Native Americans. Native Americans comprise the Ethnic and Cultural Community Advisory Committees (ECCAC) and are offered stipends to participate fully. The committee members are asked to outreach and engage their community and the above table illustrates the growth of that activity within the Native American community.

Gender Disparities

According to the World Health Organization, "Gender differences exist in patterns of help seeking for psychological disorder. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of inpatient care… depression is almost always reported to be twice as common in women compared with men across diverse societies and social contexts." The California public mental health system gender utilization data illustrates the same parallel. Table 3 indicates the average payment between males and females.

Table 3

Statewide Comparison of Cost Per Beneficiary Served Per Gender Age 18-59				
Gender	Average Payment in 2005	Average Payment in 2006	Average Payment in 2007	Average Payment in 2008
Female	$3,083	$3,142	$3,158	$3,070
Male	$4,289	$4,350	$4,374	$4,227

The disparity shows a $1200.00+ gap in cost per beneficiary related to female/male payments. Females consistently over the years show a disparity.

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

Page 23 of the Application Guidance

Start Year:
2012

End Year:
2013

Number	State Priority Title	State Priority Detailed Description
1	Treatment and support for individuals without insurance	Focus program and system improvements toward treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
2	Treatment and support for low-income individuals who will not be covered under the Affordable Care Act	Access the gap for those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
3	Improve primary prevention activities	Improve primary prevention (universal, selective and indicated) activities and services for persons not yet identified as needing treatment.
4	Improve collection of perfomance and outcome data	Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.
		California has also suffered from a significant shortage of public mental health workers with high vacancy rates exist in certain occupational classifications. There is a recognized lack of diversity in the workforce, poor geographic distribution of existing mental health workers, and under-representation of individuals with client and family member experience in the provision of services and supports. Particularly, severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, older adults and diverse ethnic/cultural populations heretofore unserved or underserved. Minorities are underrepresented among mental health providers, researchers, administrators, policymakers, and consumer and family organizations. Furthermore, racial and ethnic minorities continue to be underrepresented, relative to their proportion of the U.S. population, within the core mental health professions; psychiatry, psychology, social

5	Support initiatives that address professional shortages	work, counseling, and psychiatric nursing. Under the MHSA Workforce Education and Training (WET) programs, DMH has contracted with agencies to address specific needs and disparities. DMH has a MOU with the state Office of Statewide Health Planning Department (OSHPD). As a part of that MOU, OSHPD has coordinated efforts with DMH to assist counties in accessing additional areas of revenue and support for solving professional shortages. Within the past four years, California has had 64 applications to Health Resources and Services Administration (HRSA) for mental health professional shortage areas approved, resulting in a total of 163 California communities being federally designated as mental health professional shortage areas. This is a 48 percent increase from SFY 08-09 to SFY 10-11. Mental health professional shortage area designation provides the community designated access to federal benefits to increase mental health professionals in designated shortage areas. Benefits include student loan repayment, scholarships and scholar placement programs, visa waiver programs, bonuses to psychiatrists, and a drug discount program. Additionally, under the MHSA WET component, county mental health departments are to include fundamental concepts and core values relative to cultural competence by developing and implementing recruitment, retention and promotion strategies to effectively address the needs of particular racial/ethnic, cultural, and /or linguistic populations or community being served. Due to current economic hardships and cut backs, the retention of multilingual and multicultural mental health service providers is a challenge. Furthermore, workforce strategies to create career pathways and educational stipends are limited.
6	Reduce the number of counties with underserved Hispanics	Latinos in California make up the largest in the nation at over 14 million strong (per 2010 census data) yet are continually and historically underserved in the public mental health system. The disparities lie in areas of access to care, appropriateness of care, and availability of care. According to a 2009 presentation conducted by the University California Davis Center for Reducing Disparities, since the 1980s, studies have shown that Latinos are more likely to: Delay or not seek mental health care; Receive less adequate care; and Terminate care earlier. Additional data indicates Latino children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or a mental health setting. Latinos continue to have poor access to specialty mental health care and more likely to seek mental health services in the primary care setting. Stigma is a major obstacle to Latino help seeking behavior and underserved populations are significantly under-represented in mental health research. Language capacity continues to be a large barrier to services: Spanish is a threshold language in 51 out of 58 California counties (a threshold language is defined as a primary language of 3,000 individuals or 5% of the population). Language access continues to be a major barrier to access and quality of mental health care. Per the California External Quality Review Organization 2009-10 Statewide Report: In Medi-Cal, “Hispanic beneficiaries are underserved compared to those eligible” and in 38 of 58 counties, Hispanics are below the statewide cost per Hispanic (Medi-Cal) beneficiary.
		Latinos in California make up the largest in the nation at over 14 million strong (per 2010 census data) yet are continually and historically underserved in the public mental health system. The disparities lie in areas of access to care, appropriateness of care, and availability of care. According to a 2009 presentation conducted by the University California

7	Reduce disparities in expenditures for Hispanic Medi-Cal beneficiaries	Davis Center for Reducing Disparities, since the 1980s, studies have shown that Latinos are more likely to: Delay or not seek mental health care; Receive less adequate care; and Terminate care earlier. Additional data indicates Latino children tend to receive mental health services through juvenile justice and child welfare systems more often than through schools or a mental health setting. Latinos continue to have poor access to specialty mental health care and more likely to seek mental health services in the primary care setting. Stigma is a major obstacle to Latino help seeking behavior and underserved populations are significantly under-represented in mental health research. Language capacity continues to be a large barrier to services: Spanish is a threshold language in 51 out of 58 California counties (a threshold language is defined as a primary language of 3,000 individuals or 5% of the population). Language access continues to be a major barrier to access and quality of mental health care. Per the California External Quality Review Organization 2009-10 Statewide Report: In Medi-Cal, “Hispanic beneficiaries are underserved compared to those eligible” and in 38 of 58 counties, Hispanics are below the statewide cost per Hispanic (Medi-Cal) beneficiary.
8	Target underserved and inappropriately served African Americans	Almost 2.3 million African Americans live in California, per 2010 census data. According to the African American Utilization Report 2011, “Most behavioral health care programs in California serve African Americans at a disproportionately higher rate than other ethnic communities, and these services are provided in extremely restrictive (often involuntary) settings such as hospitals and jails.” In Alameda County, the second largest African American population in California, “low income African Americans with serious mental illness (and co-occurring disorders) represent 25% of our population, yet receive 40% of all mental health services.” Further disparities include the African-American penetration rate of 13.57% compared to Hispanics at 4.81%, and Asian Pacific Islanders at 4.18%. In 2008, African Americans in California represented 10% of the Medi-Cal average monthly unduplicated eligibles yet were served at 16%, a disproportionately served community in California. Behavioral health care programs in California serve African Americans at a disproportionately higher rate than other ethnic communities. These services are provided in an extremely restrictive, often involuntary, setting such as hospitals and jails. According to DMH Medi-Cal paid claims data, the utilization rate by African American clients for 24-hour mental health services, which include psychiatric inpatient hospital services, was 14.8%. To further illustrate the gap, one county’s data indicates 33% African American transition age youth (TAY) are eligible for Medi-Cal yet virtually 50% of Medi-Cal clients are African American TAY.
		California is home to one of the largest tribal populations in the United States and reflects a broad number of tribes and tribal people who practice varying degrees of native traditions and culture. Add the fact that California is home to over 100 federally recognized tribes, and it is easy to see that there is just not one approach to outreach and engage tribal communities in mental health care services today (Inter-Tribal Council of California, Native American Resource Directory). Nationally, there is approximately 562 federally recognized tribes, plus an unknown number of tribes that are not federally recognized. The population of American Indian/Alaska Natives (AI/AN) including those of more than one race, was estimated at 4.9 million, making up 1.6 percent of the total population as of July 1, 2008 according to the Census Bureau; this is projected to rise to 8.6 million, 2

9	Target unserved, underserved and inappropriately served Native Americans	percent of the total population, by the year 2050. We are all aware of the disparity in health status, including mental health, within Native communities. There are many factors which influence the mental health and well-being of Native Americans across California. Depression, historical trauma, substance abuse, access to clinical counseling and lack of access to traditional healing practices are just a few of those factors. In 2008, the Surgeon General reported increased risk for depression and substance abuse and stated that AI/AN are overrepresented among high-need populations for mental health services. The report states elevated rates of homelessness (8% versus 2%), substance abuse (70% versus 11-32%), and incarceration with 1 in every 25 AI/AN adults in the criminal justice system (USDHHS 2008). The 2007 California Health Interview Survey, conducted by the University of California Los Angeles, showed 15.8% of adult AI/AN reported psychological distress in the past compared to 8.2% for non AI/AN, 2007 California Health Interview Survey (CHIS). According to the Center for Disease Control and Prevention, in 2007, a total of 34,598 suicides occurred in the United States - 83.5% of the suicides were among Non-Hispanic whites, 7.1% among Hispanics, 5.5% among non-Hispanic blacks, 2.5% among Asian/Pacific Islanders, and 1.1% among American Indians/Alaska Natives. Suicide rates by race/ethnicity and age group demonstrated different patterns. Though the greatest percentage of suicides occurred among Hispanic whites, the highest race/ethnicity and age specific rates were among American Indian/Alaska Native adolescents and young adults. In each of the groups, suicide rates were higher for males than for females.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

Page 23 of the Application Guidance

Start Year:
2012

End Year:
2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		Address disparities in services to California's diverse racial, ethnic and cultural communities. The service strategies are described below. The DMH OMS is working with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial, ethnic and cultural communities. The following is a list of activities that demonstrates the efforts of the OMS in partnership with		

multiple community and state partners to address the reduction in disparities in access, quality of care and outcomes for racial ethnic and cultural communities in our state. o Embedding cultural competency into program policy and planning is a key role of the OMS. A major focus of this office has been to integrate policies and standards in the MHSA programs and services that are being developed with these new mental health resources. o Currently under MHSA PEI guidelines, $60 million dollars have been targeted over four years for a state administered program to address reducing disparities for racial ethnic populations. OMS is working with community partners to develop a strategic plan for the development of programs and services under this targeted state program. o OMS continues to

Reduce the number of counties with underserved Hispanics	Decrease the number of counties with Hispanic Medi-Cal beneficiaries who are underserved .	conduct oversight of the California Reducing Disparities Project (CRDP), a $3 million multi-year contract to develop a comprehensive strategic plan to reduce disparities in the public mental health system. The CRDP focuses on five populations to focus on: African Americans, Asian/Pacific Islanders, Latinos, LGBTQ, and Native Americans. DMH entered into contracts with representative organizations from these communities to develop population-specific workgroups to provide reports that will inform the development of a comprehensive statewide plan to identify new approaches toward the reducing of disparities. o OMS oversees the implementation of translation services for its statewide partners. o The OMS is an active member of the MHSOAC Cultural	Decrease the number of counties with Hispanic Medi-Cal beneficiaries who are underserved compared to White Medi-Cal beneficiaries from 38 counties to 36 counties.	Using data prepared by the California External Quality Review Organization (based on Medi-Cal Eligibility Data System (MEDS), and Short-Doyle/Medi-Cal and psychiatric inpatient approved claims), compare the average payment per Medi-Cal beneficiary served for Hispanics and Whites. Compare the number of counties with lower average payment for Hispanics than Whites to measure decrease in the number of counties with underserved Hispanics.

and Linguistic Competence Committee. Currently, OMS is working closely with MHSOAC CLCC on developing new disparities outcomes measures. o The CMHPC Cultural Competence Committee's mission is to reduce disparities in the mental health system. One of its objectives is to identify performance indicators that measure disparities, generate data for those indicators; determine causes of disparities, and to develop solutions for this problem. o The DMH OMS is a member of the CMHDA, Social Justice Advisory committee (SJAC). The purpose of the SJAC is to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and

	recovery in California's communities. o DMH has provided funds to local mental health agencies for training on cultural and language competency. o OMS chairs the State Department of Social Services State Interagency Team (SIT), workgroup to Eliminate Racial, Ethnic Health Disparities in Children's programs. o DMH OMS participates in the MHSA Full Service Partnership (FSP) Advisory Committee and its FSP Cultural Competence Tool Kit Sub-Committee help to address bringing cultural relevant practices to those seeking services and supports in the public mental health system. The OMS consults on this project, which is implemented by CIMH.		
	Address disparities in services to California's diverse racial, ethnic and cultural		

communities. The service strategies are described below. The DMH OMS is working with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial, ethnic and cultural communities. The following is a list of activities that demonstrates the efforts of the OMS in partnership with multiple community and state partners to address the reduction in disparities in access, quality of care and outcomes for racial ethnic and cultural communities in our state. o Embedding cultural competency into program policy and planning is a key role of the OMS. A major focus of this office has been to integrate policies and standards in the MHSA programs and services that are being developed with

these new mental health resources. o Currently under MHSA PEI guidelines, $60 million dollars have been targeted over four years for a state administered program to address reducing disparities for racial ethnic populations. OMS is working with community partners to develop a strategic plan for the development of programs and services under this targeted state program. o OMS continues to conduct oversight of the California Reducing Disparities Project (CRDP), a $3 million multi-year contract to develop a comprehensive strategic plan to reduce disparities in the public mental health system. The CRDP focuses on five populations to focus on: African Americans, Asian/Pacific Islanders, Latinos, LGBTQ, and Native Americans. DMH entered into contracts with representative

Reduce disparities in expenditures for Hispanic Medi-Cal beneficiaries	Decrease disparities for Hispanics in expenditures per Medi-Cal beneficiary.	organizations from these communities to develop population-specific workgroups to provide reports that will inform the development of a comprehensive statewide plan to identify new approaches toward the reducing of disparities. o OMS oversees the implementation of translation services for its statewide partners. o The OMS is an active member of the MHSOAC Cultural and Linguistic Competence Committee. Currently, OMS is working closely with MHSOAC CLCC on developing new disparities outcomes measures. o The CMHPC Cultural Competence Committee's mission is to reduce disparities in the mental health system. One of its objectives is to identify performance indicators that measure disparities, generate data for	Decrease the difference between Hispanics and Whites in average payment per Medi-Cal beneficiary from $173 to $150.	Using data prepared by the California External Quality Review Organization (based on Medi-Cal Eligibility Data System (MEDS), and Short-Doyle/Medi-Cal and psychiatric inpatient approved claims), compare the average payment per Medi-Cal beneficiary served for Hispanics and Whites. Reduce the difference between Hispanics and Whites in average payment per beneficiary to measure reduction in the disparities in service expenditures.

those indicators; determine causes of disparities, and to develop solutions for this problem. o The DMH OMS is a member of the CMHDA, Social Justice Advisory committee (SJAC). The purpose of the SJAC is to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and recovery in California's communities. o DMH has provided funds to local mental health agencies for training on cultural and language competency. o OMS chairs the State Department of Social Services State Interagency Team (SIT), workgroup to Eliminate Racial, Ethnic Health Disparities in Children's programs. o DMH OMS participates in the MHSA Full Service Partnership

	(FSP) Advisory Committee and its FSP Cultural Competence Tool Kit Sub-Committee help to address bringing cultural relevant practices to those seeking services and supports in the public mental health system. The OMS consults on this project, which is implemented by CIMH.		
	Address disparities in services to California's diverse racial, ethnic and cultural communities. The service strategies are described below. The DMH OMS is working with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial, ethnic and cultural communities. The following is a list of activities that demonstrates the efforts of the OMS in partnership with multiple community		

and state partners to address the reduction in disparities in access, quality of care and outcomes for racial ethnic and cultural communities in our state. o Embedding cultural competency into program policy and planning is a key role of the OMS. A major focus of this office has been to integrate policies and standards in the MHSA programs and services that are being developed with these new mental health resources. o Currently under MHSA PEI guidelines, $60 million dollars have been targeted over four years for a state administered program to address reducing disparities for racial ethnic populations. OMS is working with community partners to develop a strategic plan for the development of programs and services under this targeted state program. o OMS continues to

Target underserved and inappropriately served African Americans	Decrease over-utilization of more restrictive mental health services (including psychiatric inpatient hospital services) by African Americans.	conduct oversight of the California Reducing Disparities Project (CRDP), a $3 million multi-year contract to develop a comprehensive strategic plan to reduce disparities in the public mental health system. The CRDP focuses on five populations to focus on: African Americans, Asian/Pacific Islanders, Latinos, LGBTQ, and Native Americans. DMH entered into contracts with representative organizations from these communities to develop population-specific workgroups to provide reports that will inform the development of a comprehensive statewide plan to identify new approaches toward the reducing of disparities. o OMS oversees the implementation of translation services for its statewide partners. o The OMS is an active member of the MHSOAC Cultural and Linguistic	Decrease over-utilization of Medi-Cal 24-hour mental health services (including psychiatric inpatient hospital services) by African Americans, as measured by Medi-Cal paid claims data, from 14.8% to 13%.	Using Short-Doyle/Medi-Cal and psychiatric inpatient approved claims data, analyze the service utilization by racial/ethnic group and mode of service to obtain the percentage of mode 05 (24-hour) services received by African American clients. Determine if the percentage of African American clients receiving 24-hour services has been reduced from 14.8% to 13%.

Competence Committee. Currently, OMS is working closely with MHSOAC CLCC on developing new disparities outcomes measures. o The CMHPC Cultural Competence Committee's mission is to reduce disparities in the mental health system. One of its objectives is to identify performance indicators that measure disparities, generate data for those indicators; determine causes of disparities, and to develop solutions for this problem. o The DMH OMS is a member of the CMHDA, Social Justice Advisory committee (SJAC). The purpose of the SJAC is to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and

	recovery in California's communities. o DMH has provided funds to local mental health agencies for training on cultural and language competency. o OMS chairs the State Department of Social Services State Interagency Team (SIT), workgroup to Eliminate Racial, Ethnic Health Disparities in Children's programs. o DMH OMS participates in the MHSA Full Service Partnership (FSP) Advisory Committee and its FSP Cultural Competence Tool Kit Sub-Committee help to address bringing cultural relevant practices to those seeking services and supports in the public mental health system. The OMS consults on this project, which is implemented by CIMH.		
	Address disparities in services to California's diverse racial, ethnic and cultural		

communities. The service strategies are described below. The DMH OMS is working with multiple partners at the state, local and community and university levels to address the disparities in services to California's diverse racial, ethnic and cultural communities. The following is a list of activities that demonstrates the efforts of the OMS in partnership with multiple community and state partners to address the reduction in disparities in access, quality of care and outcomes for racial ethnic and cultural communities in our state. o Embedding cultural competency into program policy and planning is a key role of the OMS. A major focus of this office has been to integrate policies and standards in the MHSA programs and services that are being developed with these new mental

health resources. o Currently under MHSA PEI guidelines, $60 million dollars have been targeted over four years for a state administered program to address reducing disparities for racial ethnic populations. OMS is working with community partners to develop a strategic plan for the development of programs and services under this targeted state program. o OMS continues to conduct oversight of the California Reducing Disparities Project (CRDP), a $3 million multi-year contract to develop a comprehensive strategic plan to reduce disparities in the public mental health system. The CRDP focuses on five populations to focus on: African Americans, Asian/Pacific Islanders, Latinos, LGBTQ, and Native Americans. DMH entered into contracts with representative

Target unserved, underserved and inappropriately served Native Americans	Decrease reports of psychological distress in Native Americans.	organizations from these communities to develop population-specific workgroups to provide reports that will inform the development of a comprehensive statewide plan to identify new approaches toward the reducing of disparities. o OMS oversees the implementation of translation services for its statewide partners. o The OMS is an active member of the MHSOAC Cultural and Linguistic Competence Committee. Currently, OMS is working closely with MHSOAC CLCC on developing new disparities outcomes measures. o The CMHPC Cultural Competence Committee's mission is to reduce disparities in the mental health system. One of its objectives is to identify performance indicators that measure disparities, generate data for those indicators;	As reported by the California Health Information (CHIS) survey conducted by University of California at Los Angeles (UCLA), decrease reports of psychological distress by Native Americans from 15.8% to 14%.	The CHIS survey is a random-dial telephone health survey of 50,000 Californians administered biennially by (UCLA). The CHIS survey includes a variable measuring psychological distress within the past year. Based on the 2007 survey, 15.8% of adult American Indian/Alaskan Native (AI/AN) respondents reported psychological distress within the past year. Using the same variable, determine if the percentage of AI/AN respondents decreased to 14% or less based on data from the 2009 survey.

determine causes of disparities, and to develop solutions for this problem. o The DMH OMS is a member of the CMHDA, Social Justice Advisory committee (SJAC). The purpose of the SJAC is to advocate for equity and full inclusion of vulnerable populations and secure social justice as measured by access to necessary quality services that promote mental health, wellness, resiliency and recovery in California's communities. o DMH has provided funds to local mental health agencies for training on cultural and language competency. o OMS chairs the State Department of Social Services State Interagency Team (SIT), workgroup to Eliminate Racial, Ethnic Health Disparities in Children's programs. o DMH OMS participates in the MHSA Full Service Partnership

		(FSP) Advisory Committee and its FSP Cultural Competence Tool Kit Sub-Committee help to address bringing cultural relevant practices to those seeking services and supports in the public mental health system. The OMS consults on this project, which is implemented by CIMH.		
Treatment and support for individuals without insurance	Develop a comprehensive strategy to improve treatment and support services for individuals without insurance	Focus program and system improvements toward treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	DMH intends to re-evaluate, create, and track performance indicators for State-identified target populations. Due to the short timeframes between publication of the draft guidelines for the Federal Fiscal Year (FFY) 2012-2013 Block Grant Application, the organizational changes currently occurring within DMH and California State Government, as well as reduced staffing resources, DMH was not able to develop new performance indicators for the federally required target populations. We are requesting technical assistance from SAMHSA to assist us in establishing performance indicators and collecting measurable data on federally required target populations (state priorities 1 through 5). We are also requesting technical assistance on how to measure disparities in service utilization by California’s diverse racial, ethnic and cultural communities and services to veterans and their families (state priorities 6 through 9). Data for measuring changes in performance indicators will be determined in the coming year based on stakeholder input and technical assistance from SAMHSA.
				DMH intends to re-evaluate, create, and track performance indicators for State-identified target populations. Due to the short timeframes

Treatment and support for low-income individuals who will not be covered under the Affordable Care Act	Develop a comprehensive strategy to improve treatment and support services for individuals who will not be covered under the Affordable Care Act	Access the gap for those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery.	Please refer to the explanation under "Description of Collecting and Measuring Changes in Performance Indicator" below.	between publication of the draft guidelines for the Federal Fiscal Year (FFY) 2012-2013 Block Grant Application, the organizational changes currently occurring within DMH and California State Government, as well as reduced staffing resources, DMH was not able to develop new performance indicators for the federally required target populations. We are requesting technical assistance from SAMHSA to assist us in establishing performance indicators and collecting measurable data on federally required target populations (state priorities 1 through 5). We are also requesting technical assistance on how to measure disparities in service utilization by California's diverse racial, ethnic and cultural communities and services to veterans and their families (state priorities 6 through 9). Data for measuring changes in performance indicators will be determined in the coming year based on stakeholder input and technical assistance from SAMHSA.
Improve primary prevention activities	Develop statewide strategies to improve mental health prevention and early intervention	Improve primary prevention (universal, selective and indicated) activities and services for persons not yet identified as needing treatment.	Please refer to the explanation under "Description of Collecting and Measuring Changes in Performance Indicator" below.	DMH intends to re-evaluate, create, and track performance indicators for State-identified target populations. Due to the short timeframes between publication of the draft guidelines for the Federal Fiscal Year (FFY) 2012-2013 Block Grant Application, the organizational changes currently occurring within DMH and California State Government, as well as reduced staffing resources, DMH was not able to develop new performance indicators for the federally required target populations. We are requesting technical assistance from SAMHSA to assist us in establishing performance indicators and collecting measurable data on federally required target populations (state priorities 1 through 5). We are also requesting technical assistance on how to measure disparities in service utilization by California's diverse racial, ethnic and cultural communities and services to veterans and their families (state priorities 6 through 9). Data for measuring changes in performance indicators will be determined in the coming year based on stakeholder input and technical assistance from SAMHSA.

Improve collection of perfomance and outcome data	Increase the state's ability to collect performance outcome data that can be utilized for program management decisions at the local, state and national levels.	Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	DMH intends to re-evaluate, create, and track performance indicators for State-identified target populations. Due to the short timeframes between publication of the draft guidelines for the Federal Fiscal Year (FFY) 2012-2013 Block Grant Application, the organizational changes currently occurring within DMH and California State Government, as well as reduced staffing resources, DMH was not able to develop new performance indicators for the federally required target populations. We are requesting technical assistance from SAMHSA to assist us in establishing performance indicators and collecting measurable data on federally required target populations (state priorities 1 through 5). We are also requesting technical assistance on how to measure disparities in service utilization by California’s diverse racial, ethnic and cultural communities and services to veterans and their families (state priorities 6 through 9). Data for measuring changes in performance indicators will be determined in the coming year based on stakeholder input and technical assistance from SAMHSA.
		DMH intended focus for improvement strategies will be: • Critical shortage of public mental health providers (i.e. child psychiatrists, psychiatric technicians, nurses, and other clinical staff such as professionals trained to serve the elderly and other special populations). Addressing this shortage may		

encompass: o Award stipends to graduate students in marriage and family therapy, psychiatric mental health nurse practice, clinical psychology, and social work. o Collaborating through a partnership with OSHPD in order to add a mental health track to the Residency Program for Physician Assistants to address the shortage of individuals who can administer psychotropic medications. o Collaborating through a partnership with OSHPD Health Professions Education Foundation (OSHPD -HPEF) to award a total of $2.5 million to qualified mental health professionals throughout California. o Under the MHSA WET component, many county mental health departments put in place strategies and actions that to

Support initiatives that address professional shortages	Support initiatives that address the existing shortage of public mental health workers	correct mental health disparities by, for example, developing and implementing recruitment, retention and promotion strategies to effectively address the needs of particular racial/ethnic, cultural, and /or linguistic populations or community being served. These strategies and actions were consistent with the guidelines promulgated by the DMH. o The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children and Families (UACF), and the National Alliance for the Mentally Ill – California (NAMI) have expanded their efforts to reach consumers and family members with self-help technical assistance and train-the-	Please refer to the explanation under "Description of Collecting and Measuring Changes in Performance Indicator" below.	DMH intends to re-evaluate, create, and track performance indicators for State-identified target populations. Due to the short timeframes between publication of the draft guidelines for the Federal Fiscal Year (FFY) 2012-2013 Block Grant Application, the organizational changes currently occurring within DMH and California State Government, as well as reduced staffing resources, DMH was not able to develop new performance indicators for the federally required target populations. We are requesting technical assistance from SAMHSA to assist us in establishing performance indicators and collecting measurable data on federally required target populations (state priorities 1 through 5). We are also requesting technical assistance on how to measure disparities in service utilization by California's diverse racial, ethnic and cultural communities and services to veterans and their families (state priorities 6 through 9). Data for measuring changes in performance indicators will be determined in the coming year based on stakeholder input and technical assistance from SAMHSA.

trainer curricula, such as Educate, Equip and Support –Building Hope, Peer-to-Peer, Family -to-Family, and Wellness Recovery Action Planning. Moreover, collaborating through a partnership with the Human Resources Committee in order to continue its activities on the Human Resource Project, which address the critical human resources needs of the mental health system in California. • Implement strategies to increase diversity in the workforce, improve distribution of existing mental health workers, and increase representation of individuals with client and family member experience in the provision of services and supports. The State plans to develop a comprehensive and detailed Workforce Needs Assessment to focus on statewide capacities

		and needs based upon skills and functions by seeking input from mental health clients and family members/caregivers, the CMHPC, the MHSOAC, the CMHDA, and other stakeholders in the development of this assessment.	

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

Page 29 of the Application Guidance

Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	DMH exclusively uses grant/contract reimbursements to our 58 counties in the form of quarterly payments based upon quarterly expenditure reports submitted by the counties to DMH.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

Page 30 of the Application Guidance

Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	10-25% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	26-50% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	10-25% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	<10% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	10-25% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	10-25% 6
System improvement activities		<10% 6
Other		<10% 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

Page 36 of the Application Guidance

Start Year: 2012

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$	$	$	$	$
Other	Unspecified	$	$	$	$	$
Other	Total	$	$	$	$	$

Footnotes:

Please refer to the SAPT Block Grant for figures. Page 31 of the FY 2012 Federal Guidance states that Table 6, the Primary Prevention Checklist, is "for projecting expenditures for substance abuse activities."

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

Page 38 of the Application Guidance

Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$	$	$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$	$	$	$	$
6. Other 24 Hour Care	$	$	$	$	$	$
7. Ambulatory/Community Non-24 Hour Care	$	$	$	$	$	$
8. Administration (Excluding Program and Provider Level)	$	$	$	$	$	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$	$	$	$	$	$
10. Subtotal (Rows 5, 6, 7, and 8)	$	$	$	$	$	$
11. Total	$	$	$	$	$	$

Footnotes:

Please refer to the SAPT Block Grant for figures. Page 31 of the FY 2012 Federal Guidance states that Table 7, the Projected State Agency Expenditure Report, "requests information regarding projected total expenditure for 2012 under the SABG."

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

Page 40 of the Application Guidance

Start Year: 2012

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$		$			$
2. Quality Assurance	$		$			$
3. Training (Post-Employment)	$		$			$
4. Education (Pre-Employment)	$		$			$
5. Program Development	$		$			$
6. Research and Evaluation	$		$			$
7. Information Systems	$		$			$
8. Total	$	$	$	$	$	$

Footnotes:

Please refer to the SAPT Block Grant for figures. Page 31 of the FY 2012 Federal Guidance states that Table 8 "requests information regarding the SABG Projected Resource Development Expenditures."

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

Page 41 of the Application Guidance

Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

Client and Family Members Directing Their Own Services

For California's Federal Fiscal Year 2012 State Plan, sections D (Activities that Support Individuals in Directing the Services) and L (Involvement of Individuals and Families) will be combined into one submission. For the purposes of the State Plan, the terms "client" and "consumer" are used interchangeably to signify an individual that receives or has received mental health services.

DMH's goal is to expand and maintain a public mental health workforce, which includes clients and family members, sufficient in size, diversity, skills and resources to deliver compassionate, safe, timely and effective mental health services to all individuals who are in need, and their families and caregivers, and contributes to increased prevention, wellness, recovery and resilience for the people of California.

Strength-based, consumer-directed mental health service delivery that embodies the principles of wellness, recovery and resilience is being recognized as essential to preventing costly and often involuntary treatment. It also enables individuals to live, work, learn, and fully participate in the communities of their choice.

Two of the fundamental concepts to this mental health service delivery approach are:

- Consumers actively participating in and planning their individual service and treatment planning; and
- Supporting, promoting, facilitating, and maintaining consumer and family member involvement in both community mental health service delivery as well as system-wide policy decisions.

Medi-Cal

All Medi-Cal services are self-directed in that the client must participate and agree with the client plan for services. California's Medicaid State Plan includes a definition of "Client Plan" related to self-directed services:

- *Client Plan* means a documented plan for the provision of services to a beneficiary who meet medical necessity criteria; it contains specific observable and/or quantifiable goals and treatment objectives, proposed type(s) of intervention, and the proposed duration of the intervention(s). A client plan is consistent with the beneficiary's diagnosis or diagnoses. A client plan is signed by the person providing the service(s), or a person representing a team or program providing services, and must include documentation of the beneficiary's participation in, and agreement with, the client plan.

Mental Health Services Act

While the MHSA has a wide scope, the largest and one of the essential elements of each county's MHSA plan lies within the CSS component, which is a provision of a client/family driven mental health system for older adults, adults, and transition age youth. Similarly, CSS supports a family-driven system of care for children and youth. Adult clients and families of children and youth identify their needs and preferences, helping to identify the services and supports that will be the most effective for them. To put it simply, their needs and preferences drive the policy and financing decisions that affect them. When providers work in full partnership with clients and families they serve, and develop individualized, comprehensive service plans, positive outcomes generally follow.

Many adults with serious mental illness and parents of children with serious emotional disturbances have limited influence over the services that they or their children receive. Increasing opportunities for clients and families to have greater choice over things such as types of service, provider choice, and how dollars are spent facilitates personal responsibility, creates an economic interest in obtaining and sustaining recovery, and shifts the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing client and family member choice protects individuals and encourages quality.

The California Code of Regulations, Title 9, Chapter 14, Section 3200, includes the following MHSA definitions:

- *Client Driven* means that the client has the primary decision-making role in identifying his/her needs, preferences, and strengths and a shared decision-making role in determining the services and supports that are the most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes.
- *Family Driven* means that families of children and youth with serious emotional disturbances have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be the most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes.

Rehabilitation and Employment Services

The importance of rehabilitation and employment services, within an effective consumer directed system of care, is supported by the values and principles of the recovery and

Psychosocial Rehabilitation models. DMH has maintained its role in providing employment services for persons with psychiatric disabilities by recognizing and building upon the interdependence of key State and local agencies. DMH has taken a leadership role in creating employment strategies, services, and systems development at both the State and county level through its collaborative partnership with the Department of Rehabilitation (DOR). The State-level Interagency Agreement between DMH and DOR provides the administrative support, training, and technical assistance for the 27 local cooperative programs to develop, expand, and/or improve their interagency employment services.

The interagency agreement with the DOR draws down federal rehabilitation funds to assist local county mental health/local DOR cooperatives to provide employment and education services. The interagency agreement provides staff for oversight of the funding and support given to the 27 cooperatives statewide. It also generates training that can be provided on a variety of topics to cooperatives without charge. This training assists cooperatives in maintaining a high standard of skill level amongst the staff serving client employment needs. This agreement has been renewed every three years for the last 30 years between DMH and DOR.

Local mental health/rehabilitation cooperative programs provide the employment and support services for persons with severe psychiatric disabilities. These employment activities are consumer-driven so that clients are central to all decision-making and service selections. These programs closely adhere to the values of comprehensive service linkages, consumer career choice, placement in a competitive and integrated environment, and proactive ongoing support. In SFY 2009-10, 6,818 persons with severe psychiatric disabilities were provided services in these 27 programs, with 724 persons meeting DOR's defined outcome of becoming successfully employed.

Training and technical assistance are the key tools used to develop the local employment programs that support the consumer's choice to work. Training is customized to meet the individualized needs of the local programs and their communities. Training sessions can be delivered by topic or can be developed in a customized series that addresses the skill development needs of the local partners. Subject matter specialists are currently contracted through DOR and the training is funded by the interagency agreement between DMH and DOR to provide statewide training and technical assistance. The subject areas address the values and principles of the recovery model as the basis for building programs and systems for employment services. All trainings are provided at no cost to the local partnership communities.

The current subject areas for training and technical assistance are: Building Systems for Employment Outcomes, Employment Challenges: Overcoming Barriers, Job Development and Employment Retention, Connecting Partner in the Design of Educational Resources, Benefits Planning, Employment Success

and Co-Occurring Disorders (Mental Health and Substance Abuse), Transition Age Youth, Cooperative Team Building: Integrating Employment into the Recovery Culture, Educational and Employment Goals from the Client's Perspective, System/Program Assessment, Planning and Development, and Developing and Implementing Technical Assistance and Customized Training.

Stakeholder Process and Public Planning

Medi-Cal State Plan Amendment (SPA) Stakeholder Process

The DHCS (the single state entity for the Federal Centers for Medicare and Medicaid) and DMH have conducted a series of stakeholder meetings to develop language for a SPA to re-define current Medicaid specialty mental health services in California to reflect current practice. These meetings have included discussions to update State Plan terminology to include recovery, resiliency, and to create service definitions that more accurately describe maintenance of current functioning, adjunctive therapy, and telemedicine. In addition, child appropriate language was included in several SPA areas. DMH received support from the stakeholder community for the transparency of the stakeholder process and openness to input from clients, family members, providers, county mental health agencies and others in the public mental health community.

During the stakeholder discussions, the State received a consensus of input to include peer support language. Since this will be an expansion of current services, peer support will be considered for a separate SPA that the State will conduct stakeholder meetings to solicit ideas and input during SFY 2011. DHCS and DMH have committed to continue stakeholder discussions during SFY 2011-12 about peer support service definition and a peer support service provider category.

MHSA Stakeholder Process

The MHSA utilizes a robust public planning and stakeholder input methodology to ensure that that consumers and family members are sufficiently represented during policy formation. An example of this occurred in the CSS MHSA component public planning process in 2005, which focused on meaningful involvement of consumers and families as full partners, from the inception of planning through implementation and evaluation of identified activities. Each CSS plan describes which services and supports that clients and/or family members will provide, and whether clients and/or families will actually run the service, or if they are participating as part of a service program, team or other entity.

In addition, MHSA Housing Applications are required to solicit input from consumers and family members to judge the adequacy and effectiveness of the support services offered.

This method is outlined in the General Requirements section of the MHSA regulations governing the Community Program Planning Process:

- "Stakeholder participation shall include representatives of unserved and/or underserved populations and family members of unserved/underserved populations."
- "Ensuring that stakeholders that reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity have the opportunity to participate…"
- "Training shall be offered, as needed, to those stakeholders, clients, and when appropriate the client's family, who are participating in the … planning process."
- "The County shall submit documentation, including a description of the methods used to circulate, for the purpose of public comment, a copy of the update, to representatives of stakeholders' interests and any other interested party…"

MHSA-Funded Contracts

Through the MHSA, DMH maintains several contracts with large statewide advocacy groups, with the intent of increasing consumer and family participation in service planning and delivery.

The California Network of Mental Health Clients contract provides the following services:

- Self-help, peer support, and mutual support groups by and for mental health clients;
- Public education and policy formation from the client's perspective;
- Cultural competency and sensitivity as representatives of clients from diverse communities;
- Membership outreach and networking of clients and client organizations; and
- Employment and career development for mental health clients.

The National Alliance for the Mentally Ill contract provides the following services:

- Expand the availability of NAMI's nine-week peer-to-peer self-help training program for consumers with severe and persistent mental illness;
- Assist consumers who participate in the peer-to-peer classes to transition to other programs such as NAMI's peer-to-peer self-help support group program, *Connections*, to help reach or sustain well-being and recovery;
- Expand and improve broad-bases consumer and family participation in the MHSA stakeholder process, especially among the unserved and underserved consumer community; and

- Improve and expand NAMI's website content to include culturally competent materials to support consumer self-help resources.

The United Advocates for Children and Families contract provides services to increase state and local capacities to promote, build, and support leadership by youth, parents and family members of children who use public mental health services. Specifically, these include:

- Increasing the meaningful participation of parents and caregivers in the development and maintenance of local mental health service systems; and
- Providing education and information about mental health policy to youth and to parents and family members of children.

The California Institute for Mental Health contract contains multiple deliverables related to consumer and family member involvement:

- *Knowledge Exchange Networks (KENs)* that help to disseminate information through peer-to-peer knowledge exchanges and shared problem solving. The intended outcomes for KENs include increased awareness and understanding of key mental health service delivery constructs: community collaboration, cultural and linguistic competence, client/family member-driven mental health system, wellness and resilience, and integrated services experiences for clients and their families.
- *Making Recovery Real*, a train-the-trainers curriculum, addresses strength-based, person-centered, culturally competent assessments, formulations service plans, and documentation.
- The *Transformational Change Pilot* program focuses on developing methods to engage community agencies, organizations, and assets in an authentic process to provide natural supports for individuals in a recovery process.
- Assist the counties in PEI and Innovation planning processes by providing training and technical assistance for successful implementation.

Working Well Together (WWT)

In addition to the contracts above, the MHSA also funds a collaborative of four statewide client, family, parent/caregiver and mental health training and technical assistance organizations (CNMHC, NAMI, UACF, and CIMH) in a project named *Working Well Together (WWT)*. Together, these organizations utilize their combined expertise, experience, grassroots network and mental health system connections to affirm wellness and recovery from mental illness.

WWT was recently awarded a contract from DMH to initiate a statewide client, family member, and parent/caregiver employment technical assistance resource

center, referred to as the WWT Technical Assistance Center (TAC). The primary goal of the WWT TAC is to ensure that public mental health agencies are prepared to recruit, hire, train, support and retain multicultural clients, family members, and parents/caregivers as employees.

The WWT TAC helps to transform the mental health system by supporting sustained development of client, family member, and parent/caregiver employment within every level of the public mental health workforce, from peer support groups to high-level policy formation. The WWT TAC was formed on a conceptual model based upon core values of consumer career choice, comprehensive service linkages, job placement in competitive and integrated employment, reasonable accommodations, and proactive and ongoing support, while expanding the model's scope by including dedicated employment opportunities and support for continued professional development of the consumer and family member workforce.

County agencies, community-based organizations, clients, family members, and parents/caregivers involved with WWT TAC envision a client and family driven, recovery-oriented public mental health system built upon the employment of multicultural clients, family members, and parents/caregivers. The deliberate and intentional involvement of these groups is a key contributor to building an effective system that improves the outcomes of those it serves while adhering to the recovery- and resiliency-based vision of the MHSA.

Wellness and Recovery Centers

The Wellness and Recovery Centers (WRCs) established throughout California through the MHSA CSS component are a shining example of DMH's intent to strengthen and maintain a client and family-driven mental health service delivery system. The purpose of the WRC is to create places that consumers can go to learn coping mechanisms and living skills in a non-judgmental environment that focuses on consumers strengths, and provide support while the consumer is in the process of recovery.

Due to the uncertainty and volatility of program funding currently affecting California, WRCs are an opportunity to "do more with less;" they are a cost effective option for counties that meet the needs of consumers more meaningfully than most of the more traditional and more costly clinical services. Many counties in California are utilizing WRCs as training grounds for consumers to develop employment skills to enter the public mental health field. In fact, a 2009 MHSA Implementation Study found that, in the seven WRCs studied, "over 80% of the staff [were] consumers and family members, largely consumers." It is also important to note that many consumers who receive services actually come back to work for the WRCs. There are over ninety WRCs in California.

The following are a few examples of model WRC programs within California:

- In Fresno County, the Blue Sky Wellness Center facilitates significant peer support and involvement as it relates to Co-Occurring Disorder Training and Consultation.
- In Orange County, the Wellness Center plan emphasizes involvement with family members as well as other peer supports, using interventions that are client-directed, while clients also provide the services. Orange County's Recovery Center notes that their services "rely on client self-management."
- In Humboldt County, the Hope Center is client-run and provides services including peer-to-peer education and support, service system navigation assistance, and linkage to services. In addition, outreach efforts are made by Hope Center's peer staff and volunteers to reach underserved people.
- In Alameda County, the Wellness and Resiliency Resource Hub promotes consumer involvement and decision-making, as well as a client/family-driven system. In addition, they train youth and family members to provide peer-to-peer services through leadership training programs.

Prevention and Early Intervention (PEI) Component

MHSA offers a "Prevention and Early Intervention" component, in which funding can be made available to counties on receipt of a county plan. Alameda County implemented several model programs that concurrently promote consumer-directed service and individual/family involvement:

- *Natural Helpers* is a peer-to-peer support service offered by and for the Native American community. Because the staff have existing ties to the community, stigma and discrimination is reduced, while access to hard-to-reach subpopulations are increased.
- *Curanderos* is a program by and for Latinos, in which an herbalist or "healer" provides *limpias* (cleansings) and other holistic methods which are meant to address traumas. Cultural wellness practices are incorporated into the *limpias*, as well as outreach and education, consultation, and early intervention activities.

Innovation Component

MHSA also offers an "Innovation" component. Several model programs include:

- Kern County's Friese HOPE (Helping Others through Peer Empowerment) House is a consumer-managed short-term 24-hour crisis residential program that provides a natural flow for consumers, from intake to graduation, and back to the community. The HOPE House places a major emphasis on consumer-provided services.
- San Luis Obispo County's *System Empowerment for Consumers, Families and Providers* was developed and implemented by consumers and family

members through several Innovation Planning Strategy sessions. This family-driven project creates a three-step process to address the paradigm which limits communication between providers and family members of local clients. The ultimate goal is educating consumers and family members about the mental health provider process; this learning process is enhanced when activities are held that deepen trust and understanding between the provider and the consumer/family.

- Marin County's *Client Choice and Hospital Prevention Program* is intended to provide community-based crisis services in a home-like environment. It combines three effective strategies: consumer-developed crisis plans, community-based crisis services, and integrated peer/professional staffing. This program reinforces the fact that Marin County strongly believes that consumer choice and empowerment are fundamental underpinnings of wellness and recovery.

Workforce Education and Training

DMH administers a number of programs designed to increase staffing in the mental health workforce.

- *Regional Partnerships* are collaborations between the mental health system and the educational systems designed to expand outreach to the multicultural communities, increase the diversity of the mental health workforce (including clients and family members), reduce stigma associated with mental illness, and to promote the use of web-based technologies and distance learning techniques.
- The *Mental Health Loan Assumption Program (MHLAP)* is a partnership between DMH and the OSHPD that awards stipends to qualified mental health professionals to offset the costs of education. The last cycle in 2010, $5.13 million was awarded to 474 individuals. Forty-five percent have obtained employment within county mental health departments, and 55 percent currently work at community-based mental health organizations. Out of three award cycles, approximately 35 percent of the awardees described themselves as clients or family members.

IV: Narrative Plan

E. Data and Information Technology

Page 42 of the Application Guidance

Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

DATA AND INFORMATION TECHNOLOGY (IT)

Overview of California's Data Systems (Unique IT Systems)

There were a total of 631,863 unduplicated clients served in SFY 2009-10, based on the Client and Service Information (CSI) System and State Hospital data. There are several automated systems at the State level that contain client, service and fiscal data from State Hospitals and county mental health programs.

Recovery-Model Outcome Reports (formerly "SHOES")

Long Term Care Services combines data generated by the Wellness and Recovery Model Support System (WARMSS) with other centrally gathered data to create reports that were formerly conducted as part of the State Hospital Outcome and Evaluation System (SHOES). The SHOES project was recently redesigned to be consistent with the Recovery Model of mental health treatment that the Department of Mental Health has adopted.

DMH'S Applications Development Section

DMH's Applications Development (AD) Section is divided into three units: State Hospital Services, County Services and Headquarters Services. The following is a brief description of some of the responsibilities of each unit:

State Hospital Services

This unit responds to the diverse business needs of the staff working in various capacities throughout the five State Hospitals. The systems they develop and maintain facilitate key hospital functions to assist in the care and treatment of approximately 5,000 patients. These systems are deemed mission critical by the DMH and interface with systems in other agencies. The following are Hospital Services systems that are either maintained or under development by the AD section:

Wellness and Recovery Model Support System (WARMSS) - The WARMSS, used by the LTC Division, is a comprehensive computer software program that records each patient's assessed needs as derived during initial treatment team planning sessions, including: patient-generated life goals, goals for each treatment session or class, available types and providers of treatment, a schedule and rosters of patients assigned to treatment sessions, degree of patient achievement of each treatment goal, changes in goals, and measures of progress in treatment. When WARMSS is deployed system-wide, DMH will be able to monitor and summarize data concerning amounts and types of treatments provided and the effectiveness of these treatments. The system is consistent with the wellness and recovery models of mental health that place special emphasis on client-driven treatment goals and services and in which services are

often provided in treatment malls with a campus atmosphere and flexibility in tailoring available treatment to individual needs.

Admission Discharge and Transfers (ADT) **-** The ADT System performs State Hospital census functions. Statistical information from this system is used for management reporting and research purposes. The system provides transactions to the Department of Developmental Services (DDS) for billing purposes. ADT contains the patient file, which is the foundation for all patient care-related hospital systems, and vital criminal and clinical history data. The system has over 500 screens and 400 standard reports. When a patient is transferred from one hospital to another, patient data is available to the new hospital. This is essential for both the patient and staff at the hospitals.

Master Billing Project (MBP) - Provides a mechanism to capture Fee-For-Service (FFS) billing information within existing and future DMH Hospital Automation Systems (HAS) applications. An automated Patient Progress Note (PPN) will help facilitate the doctors completing the documentation that is required for billing. After validation of billing this information will be passed to the DDS Cost Recovery System (CRS) for billing.

Additionally, it will enhance the Master Formulary and create Drug Utilization Review tables for the Pharmacy Hospital Operations system and Physicians' Orders System (described below). This will allow for much needed order validation using the patient's diagnosis, medical condition, and medication regimen for indications and contraindications, appropriate dosing levels and duration of therapies as well as other valuable special conditions and precautions.

Pharmacy Hospital Operations (PHO) **-** The PHO system processes medication orders and recurring non-medication orders. It generates monthly Physician Orders for renewal and information that supports unit-dose order filling functions; this includes pick lists, Medication Administration Record forms and an electronic file for the Baxter automated unit-dose dispensing machine. All medication orders are checked for Drug-to-Drug Interactions, allergies, over maximum-dose, and approval for non-formulary items. When a patient is transferred, his/her medication orders are visible to the new hospital and can be utilized by the new physician as baseline current medications for the new episode. This greatly benefits the staff and minimizes patient risk. PHO also has over 500 screens.

Physicians' Orders System (POS) - POS automates physician order entry and transmission of physicians' orders to the service provider. This reduces order turnaround time and errors, and promotes more timely and effective patient treatment. This system uses extremely complex client/server architecture to provide the user with the easiest, friendliest interface possible.

Service Usage Report (SUR) - The SUR is used to collect data from the ADT system and maintain files of county usage of beds at the hospitals. The system runs twice a day and produces summaries of daily, monthly and fiscal YTD bed usage totals. This system supports the County Contract Monitoring System (CCM), which reports over-contract use of State Hospital beds, and the Fiscal Automation System (FAS) reports, which the hospital accounting offices use to comply with certain CALSTARS cost reporting requirements.

Treatment Outcome System (TOS) - The State Hospital TOS schedules patients into treatment activities, records patient and staff attendance at those activities and produces reports for managers at the hospitals. TOS reports have been used to support departmental testimony at the yearly legislative budget hearings.

Trust Accounting Cashiering System (TACS) - The TACS accounts for patients' financial assets and associated transactions. The system records receipts from patients, their families, conservators, Social Security, etc., and disburses funds for patients' personal use and for reimbursing the cost of their care.

The Canteen subsystem allows the canteen operators to scan bar coded patient identification cards, determine patient account balances, and apply purchases and other transactions saving operators' time.

DMH Data Management Services

This unit supports, enhances and develops automated systems to facilitate oversight and program decisions for the 58 counties providing services to mental health consumers. The systems also perform billing, payment and report processing for Medi-Cal services and federal reporting requirements. The unit's primary customers are the System of Care staff at DMH Headquarters and the county program and technical staff. In addition to DMH systems support, the units also develops county-level applications, file extractions, responds to technical questions, and fosters DMH and county program and technical relationships.

To further the modernization of the county systems, the unit is also developing a decision support system that includes data from all related county and State systems to provide management reporting on access, cost and outcomes of mental health services across the entire continuum of mental health care. The unit is using the newest Internet technologies to securely provide confidential mental health information to all its appropriate and HIPAA compliant business partners.

The county technical staff is viewed as both customers and suppliers of these systems. All systems under construction are directed by the input of county technical staff, consumers and the county vendors. Although this is a more

difficult approach than previously used, there is greater county buy-in and improved county reporting.

Client and Services Information System (CSI) – The CSI system collects, edits, and reports on client demographic and service encounter information on the entire California public mental health population of approximately 500,000 people receiving 7.5 million services per year. This system works via a web browser to provide data entry and correction screens, process batch files and return errors with error identity, and pass data to and from the counties via the Information Technology Web Server. The CSI data will be integrated with other data sources to facilitate decision support.

In addition to client level data systems, there are two other systems that include county data. The County Financial Reporting System (CFRS) is a year-end cost report of all costs expended by county mental health programs. Costs are reported in the same categories that are used for statistical reporting. The Provider and Legal Entity File identifies the actual provider site as well as the legal or corporate entity, or county, that "owns" the provider. The CSI system is based on provider reporting while the CFRS is based on legal entity reporting. Through the Provider and Legal Entity file, costs reported to the CFRS by legal entity can be linked to services reported in the CSI by provider. Through this linkage process it is possible to estimate the cost of services provided to specific groups of individuals, such as youth, or people with certain diagnoses. Preliminary efforts to link the data sets for several projects have proven to be challenging. There are frequently minor differences in spelling of names or transpositions of dates that cause records not to match when they should. DMH staff will continue to work in this area to improve the matching process so that the benefit of linking the data systems can be realized.

Welfare and Institution Code (WIC) §5610 required counties to report data to DMH for non-duplicative client-based information including all information necessary to meet federal Medicaid reporting requirements, as well as any other state requirements established by law.

The current client-based information system, CSI, began July 1, 1998 and replaced the Client Discharge System (CDS). The DMH CSI System collects data pertaining to mental health clients and the services they receive at the county level. A basic principle of the CSI system is that it reflects both Medi-Cal and non-Medi-Cal clients and services provided in the County/City/Mental Health Plan program. In county-staffed providers, all clients and services must be reported. In contract providers, those clients and services provided under the contract with the county mental health program must be reported. This data is processed and stored on a database at the Health and Welfare Data Center (HWDC). Counties send a CSI submission file to DMH monthly and are required to submit data no later than 60 days after the end of the month in which the services were provided.

Consumer Perception Survey Dataset (CPS) - CCR Title 9 §3530.40 regulations require counties to "conduct a semi-annual survey to collect Consumer Perception data," and submit it to DMH within 90 days. The Consumer Perception Survey collects data using the most recent version of the national Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, and the Youth Services Survey for Families (YSS-F). The survey measures perceptions across several domains including access, quality and appropriateness, participation in treatment planning, and improvement in social functioning and social connectedness.

Historically, this survey was administered semi-annually in each county to a convenience sample of clients who received services during a two-week period. The collected data were entered into a database using a scanning and verification technology system and processed centrally at DMH headquarters in Sacramento. In 2010, an evaluation of the previous convenience sampling methodology found the convenience samples were not representative of the state mental health client population. DMH contracts with the Institute for Social Research (ISR) at California State University, Sacramento to conduct ongoing annual surveys using a statewide random sampling methodology and administering the survey through the mail. The primary goal of the pilot was to increase the representativeness of the sample and the reliability of the survey results. DMH is working to implement the Consumer Perception Survey using this model in SFY 2011-12.

Data Collection and Reporting System (DCR) – Currently, the DCR supports the collection of repeated-measures for the initial performance measures for the Mental Health Services Act Full Service Partnership outcomes assessment. The DCR is aligned within the State's vision for a comprehensive, interoperable electronic mental health record system. By leveraging Extensible Markup Language (XML) technology, DMH will be able to exchange, manage, and integrate data, as well as distribute information system changes. This solution offers both a centralized, web-based application and methods that ensure interoperability between disparate county/provider systems.

Current regulations require counties to collect FSP data (CCR Title 9 § 3620.10.) and submit it to DMH within 90 days (CCR Title 9 § 3530.30). Counties submit data for three different types of client assessments into the DCR through an online interface. The Partnership Assessment Form (PAF) gathers baseline information about the partner, while Key Event Tracking (KET) and Quarterly Assessment (3M) gather follow up information. Information is collected at intake about the status of the individual in the 12 months prior to enrollment, quarterly, and on an ongoing basis as certain key events occur. Information is collected in the following domains: Housing, Employment, Education, Criminal Justice, Other Legal Statuses such as Foster Care, and Co-Occurring Substance Abuse.

Information Technology Web Server (ITWS) – Allows for the counties to pass data files for SD/MC, the Medi-Cal Eligibility Data System (MEDS), DCR, CSI, etc. electronically to DMH as well as receive them from DMH. This greatly decreases the time required for handling and errors in the initial processing steps.

Inpatient Consolidation System (IPC) - Allows counties to view and report the inpatient claims data files provided by the fiscal intermediary (EDS) under Managed Care Phase I. Counties use this information to verify realignment offsets by DMH and reconcile paid claims with their associated Treatment Authorization Requests (TARs). DMH Managed Care and Accounting use this system to resolve county inpatient claim issues and calculate the realignment offset.

Medi-Cal Eligibility Data System (MEDS) – This file is provided to DMH monthly by the DHCS. The DMH in turn provides county mental health programs with these files to conduct analyses of their risk under capitation or block grant contracts; plan allocation of their resources; identify clients who are eligible for Medi-Cal; and identify their third party insurance coverage, if any. This system also provides counties with non-resident beneficiary information upon submission of a MEDS ID. Currently, staff are analyzing a county request to perform real-time queries of the MEDS information from their county-based integrated systems.

New Institutions for Mental Disease (NIM) - The DHCS is required to provide the federal Centers for Medicare and Medicaid Services (CMS) information on Medi-Cal beneficiaries in Institutions for Mental Disease (IMDs). This requirement is to ensure compliance with Medicaid requirements involving Federal Financial Participation (FFP) and Fee-For-Service/Medi-Cal (FFS/MC) ancillary services. In order to facilitate this requirement, this system collects the IMD information from the counties.

Omnibus Budget Reconciliation Act (OBRA) System – This system is federally mandated to refer, track and maintain the data to determine the placement and treatment for seriously mentally ill residents in Skilled Nursing Facilities (i.e. whether they require nursing care, mental treatment, both or neither). The PASARR Section (Pre-admission Screening and Resident Review) receives Level I screening documents from the facilities and determines which ones warrant the more thorough Level II evaluation. Based on the evaluation, an appropriate letter is sent to the resident, facility, physician and field office informing them of the treatment recommendations.

Provider System (PRV) – This is an on-line application for inquiry and update of provider and legal entity data, including Medi-Cal certification information; furnishing provider validation information to the CSI system; and generating

reports and files required by external entities, DHS and all county mental health plans.

Short-Doyle/Medi-Cal System (SD/MC) - This system processes claims submitted by the counties, and initiates corrections and applicable approval processes. The volume of claims processed by the DMH Specialty Mental Health SD/MC system exceeds $1.5 billion annually.

SD/MC Explanation of Balances (EOB) – This is an application to view the EOB files, which contain detailed adjudicated claims information. This application was developed and is widely used by numerous counties.

Web-Based Data Reporting System (WBDRS) – The WBDRS is an integrated technology solution which was designed to improve data quality and ease the reporting of performance measurement data by counties to DMH. This system allows for direct, on-line data entry, scanning and local data verification, and batched data upload. The submitted data are used to evaluate the quality and increase the effectiveness of mental health services for California's clients and their families.

Headquarters Services

This unit supports multiple divisions at Headquarters through the development of stand alone and server-based applications to facilitate tracking efforts and increase efficiency of day-to-day operations. Below are a few of the systems supported by the AD section:

Conditional Release Program (CONREP) - The CONREP system records patient data, provider contract information, and services received. This information is used to reimburse service providers, monitor service units and dollars, track patients and treatment compliance, and evaluate the effectiveness of the program that provides community-based services for the judicially committed. An interface with the California Department of Justice provides access to criminal history data. Statistical reports are used to notify the Legislature of program status, as well as for program monitoring and fiscal planning.

Jamison/Farabee Program - The Jamison/Farabee system was developed to track court-ordered quarterly medication reviews of patients who have been diagnosed as "Gravely Disabled." The database contains both patient and quarterly review data. The monthly statistics report summarizes the monthly review data by Review Type and Review Status. Monthly compliance checks, certified competent to consent and Rx Review counts are also included in the report. The Print Reviews report is a report of patient reviews that were completed within a date range. The report includes Reviewer Name, Review Date and Patient Name, Patient ID, Unit number and Patient's Physician. The

Non-Participant report is a list of all patients who have been terminated from the Jamison/Farabee review process.

Mentally Disordered Offender System (MDO) - The law requires that a prisoner who meets six specific MDO criteria shall be ordered by the Board of Parole Hearings to be treated by DMH as a condition of parole. The MDO system provides a comprehensive method of tracking MDO patients from the California Department of Corrections and Rehabilitation (CDCR) referral to CONREP discharge. The automated evaluation scheduling facilitates prioritization of evaluations to be conducted and references to previous evaluation results. Aggregate data regarding referrals, clinician activity, evaluation results, State Hospital population, CONREP population, and CDCR facilities are also provided.

Ombudsman's Services Data System (OSD) – This system was developed to provide a means of tracking calls received from Medi-Cal beneficiaries and/or their representatives who have questions, concerns, or complaints about their coverage. The system tracks beneficiary and representative information, and categories of issues such as accessibility, benefits/coverage, and quality of care. The system gives the Ombudsman the ability to keep notes on the nature of the call and any follow-up calls, and to record when the case was resolved and what kind of conclusion/resolution was reached.

Sexually Violent Predator System (SVP) – The SVP data system consists of several linked Microsoft Access databases containing information on potential SVP inmates referred from the CDCR and screened by DMH. The systems include inmate demographic/I.D. data, SVP record review and clinical evaluation data, DMH and "post-DMH" tracking information, research-related data, SVP evaluation accounting information, and State Hospital SVP commitment data. Portions of this data are available to Atascadero State Hospital, Coalinga State Hospital, Board of Parole Hearings, and CDCR via DMH's ITWS.

Treatment Authorization Request - Level II (TAR Level II) - The TAR Level II tracks the provider appeal process. The system contains the date the appeal is received, sends letters requesting documentation and substantiation from the providers, tracks when information is received, notes whether the decision was upheld or reversed, and generates the appropriate information letter regarding the appeal to the provider.

Outcome Reporting

DMH is measuring performance with respect to the MHSA on multiple levels, including the individual client level, the mental health program/system accountability level, and the public/community-impact level.

At the individual client level, data across several domains is measured over time using three types of assessment forms. Each set of forms is tailored based on age groups: Child/Youth (ages 0-15), Transition Age Youth (ages 16-25), Adults (ages 26-59), and Older Adults (ages 60+). The forms include the Partnership Assessment Form which gathers historical and baseline information about each client while a Key Event Tracking and Quarterly Assessment forms gather follow-up information within these same domains. The domains include: residential setting (including hospitalizations and incarcerations), education, employment, sources of financial support, legal issues/designations, emergency interventions, health status and substance abuse.

Full Service Partnerships Assessment data is reported using the DCR system. This centralized, web-based application ensures interoperability between disparate county/provider systems that combines the traditional relational data model which maximizes performance and scalability with support for the XML data type to ensure system flexibility to changes in business/data needs. By leveraging XML technology, DMH is able to exchange, manage, and integrate data from counties using their own data collection platforms. The DCR system serves as an early prototype that moves the state forward towards an Electronic Health Record (EHR) for public mental health and is aligned with the State's vision for a comprehensive, interoperable electronic mental health record system. Consistent with DMH's vision for a comprehensive and fully interoperable information system, DMH also expects to incorporate future survey forms within the DCR to provide continued support for survey administration methods.

Approximately 27,508 unduplicated individuals were reported as having participated in Full Service Partnerships in SFY 2009-10. This included 5,497 Child/Youth (ages 0-15), 6,634 Transitional Age Youth (ages 16-25), 13,199 Adults (ages 26-59), and 2,178 Older Adults (ages 60+). The baseline information collected on individuals at entry into the Full Service Partnership program reveal extremely high levels of unemployment (close to 99% for adults), frequent mental health and physical health-related emergency interventions, high levels of homelessness, higher than normal involvement with the criminal justice system and higher than normal levels of substance abuse co-occurring with serious mental illness and serious emotional disturbances.

Initial evaluation of the outcomes associated with these individuals indicates that their lives are improving in several key areas including: increased housing stability and a movement towards more positive living environments, reduced

physical and mental health-related emergency interventions, reduced involvement with the criminal justice system and reduced reports of individuals who indicate they have no sources of financial support. More information regarding the 2010 UC Berkeley School of Public Health evaluation of FSP Outcomes can be found at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/default.asp#StudiesReportsSummariesFS .

The data collected above can also be linked with data collected during the bi-annual Consumer Perception Survey sampling periods to capture clients' perceptions of the FSP services/care they receive using the nationally developed Youth Services Survey for Youth (YSS-Y), Youth Services Survey for Families (YSS-F) and MHSIP consumer surveys. Data reported to the CSI System is also linked to provide demographic information, as well as service information (which includes evidence based practices and other service strategies that are more tailored toward a client's individual needs).

Data and Information Technology

DMH uses Medicaid data from County submitted claims to perform fiscal forecasting tasks on a regular basis. DMH looks at annual dollars expended across programs and counties to determine budget needs for future years. DMH also uses claim data to monitor payment timeliness, trend service usage, and mitigate denial occurrences. In addition to claim data, counties submit Client Service Information as well as Performance Outcome data. DMH uses this data internally and externally to better anticipate and meet the needs of our behavioral health beneficiaries.

DMH Information Technology (IT) staff participate in regular meetings with a variety of internal and external groups. Some of the ongoing meetings include:

- Weekly Short Doyle Medi-Cal Steering Committee
- Weekly Project Management Meeting with DMH, ADP, and DHCS
- Weekly Policy Meeting with IT and Program staff
- Weekly County Conference Call Stakeholder meeting with Counties and Vendors
- Bi-Weekly county-led committee working to resolve IT and billing system implementation issues
- Bi-Weekly Inter-Departmental Meeting with Executives from DMH, ADP, and DHCS to monitor progress and resolve issues with the Short-Doyle II Medi-Cal claims and billing system
- Monthly CMHDA Stakeholder meeting

In addition, DMH has worked on statewide efforts with other interdepartmental groups on Health Information Exchange (HIE) and other Health information Technology (HIT) related issues for the State through a collaboration called

“eHealth”. The California Health and Human Services Agency (CHHS) works with the State Chief Information Officer (OCIO), the Department of Managed Health Care, the Business, Transportation and Housing Agency and others to oversee the State’s HIE and HIT related efforts.

DMH does not have any grants to create statewide health information exchange at this time. With the Governor’s SFY 2011-12 realignment of MHSA funds to the counties, DMH will continue the process to determine how the MHSA data exchange will be collected and through what mechanism the counties will report this information.

IV: Narrative Plan

F. Quality Improvement Reporting

Page 43 of the Application Guidance

Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

QUALITY IMPROVEMENT

Quality Improvement Reporting

External Quality Review Organization (EQRO)

As required by Title 42, Code of Federal Regulations, (CFR), sections 438.310 through 438.370, DMH has contracted with APS HealthCare to act as its EQRO. The purpose of the EQRO is to objectively assess quality, outcomes, timeliness of and access to the services provided by 56 California MHPs that contract with DMH to provide Medi-Cal specialty mental health services to Medi-Cal eligible individuals.

To that end, the APS HealthCare conducts annual external quality reviews that include the following:

1. An assessment of DMH-specified performance measures;
2. An assessment of MHP-selected performance improvement projects;
3. A periodic evaluation of selected aspects of each MHP's ongoing internal quality improvement system; and
4. A review of each MHP's health information system capability to meet the requirements of the Medi-Cal specialty mental health services program.

APS HealthCare prepares an annual report on each MHP describing a comprehensive assessment of the overall performance of the MHP in providing mental health services to Medi-Cal beneficiaries. The EQRO also prepares an aggregate report for the State based on the information gained in the assessments of the individual MHPs.

The EQRO provides up to four hours of technical assistance and consultation for each MHP annually. The intent of this activity to meet the individualized quality improvement needs of each MHP and to maximize the utility of the external review activity as a quality improvement learning experience. Because of the unique nature of the Medi-Cal managed mental health care system, calculation of performance measures is done by DMH using claims data obtained from the MHPs. Thus, in order to fully assess MHP performance, the EQRO reviews and evaluates various DMH data systems and processes, in addition to the MHPs system, for reporting claims data. The EQRO prepares an annual report that comprehensively assesses the overall performance of DMH in this capacity.

In SFY 2009-10, the EQRO revised the Key Components Review Protocol and eliminated some items in favor of emphasizing those that directly relate to the CMS's stated priorities of Access, Quality, Timeliness, and Outcomes. The EQRO also updated the Information System Capabilities Assessment (ISCA 7.0) with input from many MHP information systems stakeholders in accordance with

CMS regulations, and implemented for SFY 2010-11 reviews. The EQRO is in its seventh year of reviews.

CMHDA Quality Improvement Committee

DMH also participates in activities to support the county MHPs in their quality improvement activities. The California Quality Improvement Committee, sponsored by the CMHDA, meets several times each year and has conferences devoted to improving services quality. It is an organization of county quality improvement directors and has subdivisions for north state, south state and San Francisco bay area. The goals of the group include cross education among officers, sharing of promising practices, providing continuation education units for professionals in the system, an opportunity for the state to interface and update the counties, provide presentations by the State DMH, lawyers, advocates and consumers. The group promotes statewide awareness, consistency and quality of service delivery in county practices, and peer support and education.

Medi-Cal Waiver

California further supports the quality of services by incorporating its requirement in its 1915b Freedom of Choice Waiver. In section C of the waiver, quality improvement is specifically outlined and the state's responsibilities to report the results of monitoring quality of services is described to CMS for approval.

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, DMH provides assurance in Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, DMH provides evidence that waiver requirements were met for the most recent waiver period.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MHPs, and reviews of independent assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

Originally, DMH used a point-in-time survey method to target all consumers receiving face-to-face mental health services from county operated and contract providers during a two-week period in November and during a two-week period in May. The surveys obtained descriptive information for each consumer and include questions about consumer satisfaction with services and questions about whether the services consumers received improved their ability to function across several domains. Later, DMH contracted with California State University to

conduct the survey by mail. Currently, DMH is contracting with CIMH to support county administration of the survey to ensure quality feedback from consumers and meet the requirements of the waiver.

Quality Improvement Provisions in Title 9, Chapter 11

Although there is no single document for our State that is identified as the State's Continuous Quality Improvement (CQI) plan, we are including California's Quality Improvement provisions from the California Code of Regulations, Title 9, and the contract between the State and county Mental Health Plans for provision of Medi-Cal specialty mental health services, as these documents taken together represent the efforts in our state to ensure quality improvement processes are followed at the county level, where mental health services are implemented.

The following is the regulatory language governing the State-County agreement for quality improvement:

1810.440 - MHP Quality Management Programs
The MHP shall establish a Quality Management Program in accordance with the terms of the contract between the MHP and the Department that includes at least the following elements:

(a) A Quality Improvement Program responsible for reviewing the quality of specialty mental health services provided to beneficiaries by the MHP that:

(1) Is accountable to the director of the MHP.

(2) Has active involvement in planning, design and execution from:

(A) Providers;

(B) Beneficiaries who have accessed specialty mental health services through the MHP; and

(C) Parents, spouses, relatives, legal representatives, or other persons similarly involved with beneficiaries who have accessed specialty mental health services.

(3) Ensures that the persons participating in the Quality Improvement Program under Subsection (a)(2) shall not be subject to discrimination or any other penalty in their other relationships with the MHP as a result of their role in representing themselves and their constituencies in the Quality Improvement Program.

(4) Includes substantial involvement of a licensed mental health professional.

(5) Conducts monitoring activities including but not limited to review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

(6) Is reviewed by the MHP and revised as appropriate annually.

(b) A Utilization Management Program responsible for assuring that beneficiaries have appropriate access to specialty mental health services from the MHP that:

(1) Assures that the access and authorization criteria established in this Chapter are met.
(2) Conducts monitoring activities to ensure that the MHP meets the established standards for authorization decision making and takes action to improve performance if necessary.
(3) Is reviewed by the MHP and revised as appropriate annually.

(c) A beneficiary documentation and medical records system that meets the requirements of the contract between the MHP and the Department and requirements of State and federal law and regulation governing beneficiary documentation and medical records systems, including the following:

(1) Client plans signed (or electronic equivalent) by:

(A) The person providing the service(s), or

(B) A person representing a team or program providing services, or

(C) A person representing the MHP providing services.

(2) Documentation of the beneficiaries' participation in and agreement with their client plans. Documentation of participation in and agreement with the client plan may include, but is not limited to reference in the client plan to the beneficiary's participation in and agreement with the client plan, the beneficiary's signature on the client plan, or a description in the medical record of the beneficiary's participation and agreement with the client plan, except as follows:

(A) The MHP shall obtain the beneficiary's signature or the signature of the beneficiary's legal representative on the client plan when:

1. The beneficiary is expected to be in long term treatment as determined by the MHP and

2. The client plan provides that the beneficiary will be receiving more than one type of specialty mental health service.

(B) When the beneficiary's signature or the signature of the beneficiary's legal representative is required on the client plan under Subsection (d)(1) and the beneficiary refuses to sign the client plan or is unavailable for signature, the client plan shall include a written explanation of the refusal or unavailability.

Quality Improvement Provisions in the MHP Contract

The following are excerpts from the MHP contract outlining responsibilities and requirements for quality improvement.

EXHIBIT A – ATTACHMENT 1

Service Delivery, Administrative and Operational Requirements

Quality Management

The Contractor shall implement a Quality Management Program in accordance with Title 9, CCR, Section 1810.440 and Appendix A (consisting of five pages) and Appendix B (consisting of three pages), which are incorporated herein by reference, for evaluating the appropriateness, including over utilization and underutilization of services, and quality of the covered services provided to beneficiaries. References to the MHP in Appendices A and B are references to the Contractor. The Contractor shall provide the Department with reports generated through the Quality Management Program on request. The Contractor shall also submit timely claims to the Department that are certified in accordance with Title 9, CCR, Section 1840.112 to enable the Department to measure the Contractor's performance.

The Contractor shall ensure that all covered services delivered by organizational providers are provided under the direction of a physician; a licensed/waivered psychologist; a licensed/registered/waivered social worker; a licensed/ registered/waivered marriage and family therapist; or a registered nurse.

Quality Improvement (QI) Program Description

The MHP shall have a written QI Program Description, in which structure and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements shall be included in the QI Program Description:

1. The QI Program Description shall be evaluated annually and updated as necessary
2. The QI Program shall be accountable to the MHP Director
3. A licensed mental health staff person shall have substantial involvement in QI Program implementation
4. The MHP's practitioners, providers, consumers and family members shall actively participate in the planning, design and execution of the QI Program
5. The role, structure, function and frequency of meetings of the QI Committee and other relevant committees shall be specified as follows:
    a. The QI Committee shall oversee and be involved in QI activities, including performance improvement projects.
    b. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; and ensure follow-up of QI processes.
    c. Dated and signed minutes shall reflect all QI Committee decisions and actions.
6. The QI Program shall coordinate with performance monitoring activities throughout the MHP, but not limited to, client and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances, appeals and fair hearings and provider

appeals, assessment of beneficiary and provider satisfaction, and clinical records review

7. Contracts with hospitals and with individual, group and organizational providers shall require: cooperation with the MHP's QI Program, and access to relevant clinical records to the extent permitted by State and federal laws by the MHP and other relevant parties.

Annual QI Work Plan

The QI Program shall have an annual QI Work Plan that includes the following:

1. An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects:
   a. Monitoring of previously identified issues, including tracking of issues over time;
   b. Planning and initiation of activities for sustaining improvement, and
   c. Objectives, scope, and planned activities for the coming year, including QI activities in each of the following six areas. The QI activities in at least two of the six areas and any additional areas required by the Centers for Medicare and Medicaid Services in accordance with Title 42, CFR, Section 438.240(a)(2) shall meet the criteria identified in Title 42, CFR, Section 438.240(d) for performance improvement projects. At least one performance improvement project shall focus in a clinical area and one in a non-clinical area.

2. Monitoring the service delivery capacity of the MHP. The MHP shall implement mechanisms to assure the capacity of service delivery within the MHP:
   a. The MHP will describe the current number, types and geographic distribution of mental health services within its delivery system
   b. The MHP shall set goals for the number, type, and geographic distribution of mental health services

3. Monitoring the accessibility of services. In addition to meeting Statewide standards, the MHP will set goals for:
   a. Timelines of routine mental health appointments;
   b. Timeliness of services for urgent conditions;
   c. Access to after-hours care; and
   d. Responsiveness of the MHP's 24 hour, toll free telephone number. The MHP shall establish mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24 hour, toll-free telephone number.

4. Monitoring beneficiary satisfaction. The MHP shall implement mechanisms to ensure beneficiary or family satisfaction. The MHP shall assess beneficiary or family satisfaction by:
   a. Surveying beneficiary/family satisfaction with the MHP's services at least annually
   b. Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
   c. Evaluating requests to change persons providing services at least annually

   The MHP shall inform providers of the results of beneficiary/family satisfaction activities

5. Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices. The scope and content of the QI Program shall reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries. Annually the MHP shall identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation:
   a. These clinical issues shall include a review of the safety and effectiveness of medication practices. The review shall be under the supervision of a person licensed to prescribe or dispense prescription drugs
   b. In addition to medication practices, other clinical issue(s) shall be identified by the MHP.

6. The MHP shall implement appropriate interventions when individual occurrences of potential poor quality are identified.

7. At a minimum the MHP shall adopt or establish quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

8. Providers, consumers and family members shall evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.

9. Monitoring continuity and coordination of care with physical health care providers and other human services agencies. The MHP shall work to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries
   a. When appropriate, the MHP shall exchange information in an effective and timely manner with other agencies used by its beneficiaries

b. The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans

10. Monitoring provider appeals

11. The following process shall be followed for each of the QI work plan activities identified in items 1 through 10 above that are not conducted as performance improvement projects, to ensure the MHP monitoring the implementation of the QI Program. The MHP shall follow the steps below for each of the QI activities:
    a. Collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified
    b. Identify opportunities for improvement and decide which opportunities to pursue
    c. Design and implement interventions to improve its performance
    d. Measure the effectiveness of the interventions
    e. Incorporate successful interventions in the MHP as appropriate

MHP Delegation

If the MHP delegates any QI activities there shall be evidence of oversight of the delegated activity by the MHP. A written mutually agreed upon document shall describe:

1. The responsibilities of the MHP and the delegated entity
2. The delegated activities
3. The frequency of reporting to the MHP
4. The process by which the MHP shall evaluate the delegated entity's performance, and
5. The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations

Documentation shall verify that the MHP:

1. Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation
2. Approves the delegated entity's QI Program annually or as defined by contract terms
3. Evaluates annually whether the delegated activities are being conducted in accordance with State and MHP Standards; and
4. Has prioritized and addressed with the delegated entity those opportunities identified for improvement

EXHIBIT A – ATTACHMENT 1 – APPENDIX B

Utilization Management Program

Utilization Management (UM) Program Description

The MHP shall have a written description of the Utilization Management (UM) program, in which structures and processes are clearly defined with responsibility assigned to appropriate individuals. The following elements shall be included in the written UM program description:

1. Licensed mental health staff shall have substantial involvement in UM program implementation.

2. A description of the authorization processes used by the MHP:

    a. Authorization decisions shall be made by licensed or "waivered/registered" mental health staff consistent with State regulations.
    b. Relevant clinical information shall be obtained and used for authorization decisions. There shall be a written description of the information that is collected to support authorization decision-making.
    c. The MHP shall use the statewide medical necessity criteria to make authorization decisions.
    d. The MHP shall clearly document and communicate the reasons for each denial.
    e. The MHP shall send written notification to its beneficiaries and providers of the reason for each denial.

3. The MHP shall provide the statewide medical necessity criteria to its providers, consumers, family members and others upon request.

4. Authorization decisions shall be made in accordance with the statewide timeliness standards for authorization of services for urgent conditions established in state regulation.

5. The MHP shall monitor the UM program to ensure it meets the established standards for authorization decision making, and take action to improve performance if it does not meet the established standards.

6. The MHP shall include information about the beneficiary grievance, appeals and fair hearing processes in all denial or modification notifications sent to the beneficiary.

UM Program Evaluation

The MHP shall evaluate the UM program as follows:

1. The UM program shall be reviewed annually by the MHP, including a review of the consistency of the authorization process.

2. If an authorization unit is used to authorize services, at least every two years, the MHP shall gather information from beneficiaries and providers regarding their satisfaction with the UM program, and address identified sources of dissatisfaction.

MHP Delegation

If the MHP delegates any UM activities, there shall be evidence of oversight of the delegated activity by the MHP.

1. A written mutually agreed upon document shall describe:

    a. The responsibilities of the MHP and the delegated entity
    b. The delegated activities
    c. The frequency of reporting to the MHP
    d. The process by which the MHP evaluates the delegated entity's performance, and
    e. The remedies, including revocation of the delegation, available to the MHP if the delegated entity does not fulfill its obligations.

2. Documentation shall verify that the MHP:

    a. Evaluated the delegated entity's capacity to perform the delegated activities prior to delegation
    b. Approves the delegated entity's UM program annually
    c. Evaluates annually whether the delegated activities are being conducted in accordance with the State and MHP standards, and
    d. Has prioritized and addressed with the delegated entity those opportunities identified for improvement.

Appeals Process

DMH has also promulgated regulations governing the informal appeals process pursuant to Assembly Bill 1780, Chapter 320, Statutes of 2008, EPSDT appeal process for Legal Entities. This is the process that an MHP and/or other Legal Entity provider to appeal disallowed paid EPSDT claims resulting from a client record review. (California Code of Regulations, Title 9, section 1850.350, subdivision (b))

That process has the following main steps:

1. Submit an **informal** appeal request in writing.
2. Include documentation for each disallowance in dispute.
3. The MHP contractor shall inform the MHP at the same time by providing a copy of the appeal request with documentation to the MHP.
4. The MHP filing an appeal shall notify the contractor at the same time by providing a copy of the appeal request with documentation to the contractor.
5. The appeal shall indicate in what fashion the Legal Entity prefers to have the matter decided: documentation only, telephone conference or face-to-face conference.

Currently, DMH is developing the regulations and process for a **formal** appeal which would include having the case heard by an Administrative Law Judge. When the process development is completed and the regulations promulgated, DMH will publish it on the department website.

IV: Narrative Plan

G. Consultation With Tribes

Page 43 of the Application Guidance

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

TRIBAL CONSULTATION

Current SAMHSA block grant application

Since the publishing of the draft FFY 2012-2013 Block Grant Application guidelines in June 2011, DMH has not had sufficient time to engage in meaningful consultation with tribes on the content of this application. We believe that to initiate consultation with tribes and require rapid turnaround, without having sufficient time to incorporate the comments and changes provided, would be received as non-meaningful consultation, and would not encourage a promising relationship. For this reason, we will instead plan a robust consultation process following the submission of this application in September 2011. At that time we will have more time to engage in an honest, collaborative dialog.

Other recent state efforts that have involved consultation with tribes are described below.

1115 Waiver – California's Bridge to Reform

Over the past several years California has been engaged in an extensive effort to capture stakeholder input for the purposes of developing a Section 1115 Comprehensive Waiver/Demonstration proposal and Implementation plan. The DHCS convened a Stakeholder Advisory Committee to engage stakeholders in the preparation of an Implementation Plan. This committee consisted of health and human services advocates, providers and beneficiaries. In addition to the Stakeholder Advisory Committee, DHCS also formed and convened Technical Workgroups as a resource to assist with the details of the waiver proposals and implementation plan.

California's 103 federally recognized tribes have been involved in the Section 1115 Comprehensive Waiver development through a series of presentations and discussions, posting of waiver updates on the DHCS web-based "Indian Health Issues Inbox", correspondence, and ongoing participation in the DHCS webcast and teleconferences of stakeholder advisory committee meetings. Waiver meetings have included involvement from California's federally recognized tribes: joint meetings of Indian Health Clinic Directors/Tribal Leaders, DHCS American Indian Health Policy Advisory Panel meeting, Annual California Indian Health Services Tribal Leaders meeting, and "California Area Indian Health Services Tribal Advisory Council."

Disparities in access to care for California Native American communities are a complex and difficult challenge. This year the DMH OMS contracted with a Native American organization called the Inter-Tribal Council of California to work with OMS and CMHDA. The contract purpose is to improve collaboration and inclusion of California tribal communities in local mental health planning, and to improve relationships and communication between county programs and local

Native American communities. A resource guide and report of survey results was developed by the Council.

DMH has designated State administrative MHSA funds to create up to five contracts to develop strategic plans specific to racial, ethnic, cultural considerations and develop solutions for reducing disparities to five populations with documented mental health disparities. One of the five targeted populations is Native Americans. The intent of the contracts is to improve outcomes by identifying community-defined evidence, strength-based solutions and strategies to eliminate barriers in the mental health systems. These strategic plans will help in the design of the $60 million Prevention and Early Intervention statewide project.

DMH is also participating in interagency meetings to discuss Indian Child Welfare Agency concerns, especially when mental health issues related to children, youth, and TAY are discussed. The focus recently has been on foster care policies related to tribal customs and culture, and federal legislation impacting these policies.

Community Defined Evidence and the California Reducing Disparities Project

In response to the call for national action to reduce mental health disparities and seek solutions for historically underserved communities in 2010, DMH launched a two-year statewide Prevention and Early Intervention effort utilizing $3 million dollars in MHSA state administrative funding as a means to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities. This initiative, entitled the CRDP, focuses on five populations: Native Americans, African Americans, Asian/Pacific Islanders, Latinos, and LGBTQ.

The development of this project began by DMH consulting with tribes and other multicultural stakeholders. After vetting and receiving feedback from stakeholders on the original design of the CRDP, DMH modified the design from one single Request for Proposal (RFP) to five; representing each racial/ethnic/cultural group listed above. Community partners were pleased with this new design as it demonstrated the value and importance of capturing community-defined strength-based promising practices from representatives and leaders from each respective community.

In March of 2010, DMH awarded contracts to the following agencies representing the five population groups:

- Native American Health Center/Native Vision (Native American)
- African American Health Institute of San Bernardino County (African American)
- Pacific Clinics (Asian Pacific Islander)

- The Regents of the University of California, Center for Reducing Health Disparities (Latinos)
- Equality California Institute (Lesbian, Gay, Bi-sexual, Transgender, and Questioning)

These groups are required to develop population-specific Strategic Planning Workgroups (SPWs) for the purpose of forming a comprehensive statewide strategic plan to identify new service delivery approaches defined by multicultural communities to eliminate barriers and reduce longstanding disparities in California's public mental health system.

As part of the CRDP, SPWs, representing the Native American population, Native Vision, a statewide project facilitated through the Native American Health Center in Oakland, California, is in the process of developing a population-specific report (strategic plan) to improve mental health and well-being across the diverse regions of tribal, rural and urban Native American populations in California. Native Vision's population report will be compiled with the other four SPWs work to create one statewide Reducing Disparities Strategic Plan that captures Native American community strategies that have been utilized for years, work well, yet has historically not been given funding to be formalized through evidence based research.

The information gathered from Native Vision's outreach efforts through Native gatherings and events were conducted in various locations statewide to include: Trinidad, Oakland, Irvine, Los Angeles, San Francisco, and Toiyabe. These lay the foundation for government entities, service providers, policy makers, and others in the mental health field to better understand the unique activities and programs that improve Native American mental health. At the gatherings, Native Vision staff facilitate discussions on ***"what is working"*** to maintain good mental health and wellness; ***"what is effective"*** when people seek help; and ***"what increases access"*** to counseling and wellness activities for Native American communities in California.

Based on community input regarding personal lived experience, cultural perspectives, and activities and programs identified as effective, this information will be captured and included in the population report. The goal is to highlight practices that work to regain mental balance and increase access to services among Native people in California.

Native Vision has an eight member SPW to guide the project "in a good way" and who represent the project on a statewide level. The workgroup is comprised of Native behavioral health professionals from across California. They are: Tony Cervantes (Native American Center for Excellence), Dan Dickerson (University of California Los Angeles), Michael Duran (Indian Health Center of Santa Clara Valley), Carrie Johnson (United American Indian Involvement), Janet King (Native American Health Center), Tene Kremling (Humboldt State University), Art

Martinez (Shingle Springs Tribal Health Program), and Martin Martinez (Redwood Valley Little River Band of Pomo Indians).

Additionally, as part of the $3 million authority for this project, the CMMC was created to capture broader tribal input (and other multicultural stakeholder input). The CMMC's primary goal will be to work toward the integration of cultural and linguistic competence into the public mental health system and to provide state level recommendations on all of community mental health service related issues. The CMMC will be pivotal in providing critical insights and assessments of systems (e.g., policies, procedures, and service plans) to collaboratively seek solutions on eliminating barriers and mental health disparities.

Statewide Strategic Planning for Reducing Behavioral Health Disparities: SAMHSA Delegation

California was selected by SAMHSA's CMHS to attend this year's Policy Summit to Address Behavioral Health Disparities within Health Care Reform. The goal is to create and implement a statewide strategic plan to reduce disparities in the context of the Affordable Care Act (ACA). DMH and ADP are the lead state agencies facilitating the development of this plan and have outreached and partnered with the Native American Health Center in Oakland to ensure tribal input in the creation of the statewide plan. The areas of focus Native American Health Center will be assisting with consultation include:

- Reducing disparities through strategic implementation of the Affordable Care Act;
- Integration of services;
- Community outreach;
- Building community capacity to provide prevention activities within the integrated services model and the continuum of care; and
- Efforts to identify and support culturally appropriate prevention activities.

The development and implementation of the California Strategic Plan will continue through SFY 2011-12 and likely beyond, as the ACA creates a broader pool of eligible multicultural populations. Tribal consultation will occur during all phases of the design, implementation, and evaluation components of the strategic action plan through on-going conference calls and in-person meetings as necessary.

IV: Narrative Plan

H. Service Management Strategies

Page 44 of the Application Guidance

Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

SERVICE MANAGEMENT STRATEGIES

Unserved and Underserved Populations

DMH is committed to identifying and addressing issues related to over- and under- utilization of federal grant funding, and other health services offered within California. One of the main issues identified by DMH is the fact that despite attempts to eliminate disparities in mental health, certain groups still remain underserved or unserved. DMH recognizes that until these problems are solved, California's mental health system will never realize its true potential.

In 2008 DMH funded a nine-month long study conducted by U.C. Davis' Center for Reducing Health Disparities for the purpose of facilitating community engagement with diverse historically underserved communities. The study was conducted via 30 focus groups in 10 counties across California. Populations represented in the study included African Americans, Hmong, Latinos, LGBTQ, Native Americans, Hawaiians and Pacific Islanders, and rural populations.

Barriers to accessibility of mental health services by the underserved and unserved include:

- Lack of availability of services;
- Lack of awareness of existing mental health services;
- Stigma;
- Barriers within the mental health system (e.g. waiting periods and eligibility requirements);
- Lack of continuity of community programs;
- Geographic isolation and lack of transportation;
- Undocumented or uncertain legal status;
- Lack of culturally and linquistically appropriate services; and
- Perceptions of mental health systems as punitive (e.g. treatment that worsens the individual's overall condition, and use of seclusion, restraints, and locked facilities).

In addition, DMH recognizes that veterans, service members, and their families are a quickly growing population that require increased access to the full array of mental health services. To this end, DMH currently oversees two MOUs; one with the California Department of Veterans Affairs, and one with the California National Guard. These MOUs are helping to build an infrastructure for information, training, education, and local referral for mental health needs for the military community in California.

As stated earlier in this document, California's field of mental health is suffering from a shortage of professionals to serve the needs of our diverse population and expansive geography. Steps taken to address this crucial problem are identified

in detail earlier in this application, in the sections on Identification of Unmet Service Needs and Critical Gaps Within the Current System, and Developing Objectives, Strategies and Performance Indicators.

Petris Report on MHSA Outcomes

January 2011 marked the six-year anniversary of the passage of the MHSA in California. The MHSA places a 1% tax on adjusted gross incomes over $1 million to be used to expand access to the public mental health system by providing funding for new types of services including the FSP program. The FSP programs provide consumers with a broad spectrum of services to aid in their movement towards recovery. This includes mental health services and supports, such as medication management, crisis intervention, case management and peer support. It also provides non-mental health services such as food, housing, respite care and treatment for co-occurring disorders, such as substance abuse. A key element of the FSP programs that are different from the current usual care is that it provides a more intensive level of care and a broader range of services.

As of February 26, 2010, $3.7 billion has been approved and/or distributed based on county requests. In addition, approximately 25,000 clients have been served by FSPs and over 400,000 clients have been served in all MHSA programs. The MHSA mandates that programs emphasize strategies that reduce seven negative outcomes: suicide, incarceration, prolonged suffering, school failure or dropout, unemployment, homelessness and removal of children from their homes. Findings from this report address five of these seven negative outcomes.

DMH commissioned a study, the Petris Report, to examine the effectiveness of the FSP programs in MHSA in SFY 2008-09. The study considered the outcomes for individuals utilizing the more intensive services of FSPs compared to individuals receiving regular mental health system care.

The most significant finding relates to homelessness. Homeless individuals who enter the FSP programs are expected to stay homeless less than one day, and after one year of participation in the FSP programs the level of homelessness remains close to zero. The reduction of homelessness is especially significant as FSP participants are, by design, more likely to be homeless or at risk of being homeless when they enter the FSP programs as compared to the average consumer in the public mental health system.

Importantly, at the other end of the housing spectrum is independent living. After 12 months of participation in the FSP programs, the proportion of consumers living independently increases by approximately 20%.

Entry into the criminal justice system is dramatically changed. The probability of being arrested drops by 56% due to participation in the FSP programs, as compared to those receiving usual care. This is a causal effect and is statistically

significant at the 95% confidence level. This reduction of arrests is impressive as FSP participants are, by design, more likely to be involved with the criminal justice system when they enter a FSP program as compared to the average consumer in the public mental health system.

Full Service Partnerships also reduce prolonged suffering. Study results indicate that participating in the FSP programs strongly reduces the odds of using mental health-related emergency rooms as compared to consumers receiving usual care. After eight months of treatment, the odds of FSP participants using mental health-related emergency services are 57% lower than those receiving usual care. At 12 months of treatment, the odds of FSP participants using mental health-related emergency services are 67% lower than those receiving usual care.

Again, this result is highly significant as consumers entering the FSP programs are above-average users of mental health-related emergency services. These results are statistically significant at the 95% confidence level.

Not only do the FSP programs reduce prolonged suffering by reducing negative outcomes, such as mental health-related emergency services, it also increases positive outcomes. Functioning, which includes reduced psychiatric symptoms, improved ability to take care of one's needs and being better able to deal with problems, is increased 27% by participation in the FSP programs relative to those receiving usual care. In addition, participation in a FSP program improves overall outcomes, such as problem solving, self-control, crisis management, social effectiveness, housing, and psychiatric symptoms by 30% for some consumers. These are causal effects and are statistically significant at the 95% confidence level.

Educational outcomes are better the longer consumers remain in the FSP programs. After 12 months of participation, consumers are 30% more likely to start an education program as compared to individuals just entering the FSP program. This result is statistically significant at the 95% confidence level.

Employment outcomes are improved the longer consumers remain in the FSP programs. After 12 months of participation, there is a 25% increase in employment as compared to individuals just entering the FSP program. This result is statistically significant at the 95% confidence level.

As might be expected from the above findings, consumers in the FSP programs are more satisfied than those receiving usual care. In fact, they are 27% (or higher) more satisfied relative to those receiving usual care. This is a causal effect and is statistically significant at the 95% confidence level.

Full Service Partnerships increase functioning, outcomes of services, and general satisfaction compared to usual care, and these improvements are large.

***Emily Q v. Bonta* Lawsuit**

In 1998, DMH became involved in a California lawsuit filed against the State Department of Health Services Director Diana Bonta that proposed to increase the use of Therapeutic Behavioral Services (TBS) under the EPSDT Medicaid benefit. The judgments in that case have added responsibilities to DMH and counties for assessing and providing this service for qualifying beneficiaries under age 21. The goal of TBS is to provide a brief intensive one-on-one service that would address specific behaviors and allow a child to move to a lower level of care or to avoid going to a higher level of care including hospitalization, as specified in the definition of the affected class in the court documents.

As a result of a Federal Court Special Master's efforts to utilize an interest-based decision making process, plaintiffs and the State were able to work with state department's, county governments, local providers, and consumer and family members to reach the goals established in a TBS Nine Point Plan. The plan is detailed at http://www.dmh.ca.gov/Services_and_Programs/Children_and_Youth/EPSDT.asp .

After three years of planning, implementation, monitoring, ranking, and collaboration, in June 2011 the Federal Court released jurisdiction over the State based upon assurances that a transition plan would continue the work of the TBS Nine Point Plan as a component of the State's Medi-Cal program.

IV: Narrative Plan

I. State Dashboards (Table 10)

Page 45 of the Application Guidance

Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Reduce the number of counties with underserved Hispanics	Decrease the number of counties with Hispanic Medi-Cal beneficiaries who are underserved compared to White Medi-Cal beneficiaries from 38 counties to 36 counties.	é
Reduce disparities in expenditures for Hispanic Medi-Cal beneficiaries	Decrease the difference between Hispanics and Whites in average payment per Medi-Cal beneficiary from $173 to $150.	é
Target underserved and inappropriately served African Americans	Decrease over-utilization of Medi-Cal 24-hour mental health services (including psychiatric inpatient hospital services) by African Americans, as measured by Medi-Cal paid claims data, from 14.8% to 13%.	é
Target unserved, underserved and inappropriately served Native Americans	As reported by the California Health Information (CHIS) survey conducted by University of California at Los Angeles (UCLA), decrease reports of psychological distress by Native Americans from 15.8% to 14%.	é
Treatment and support for individuals without insurance	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	é
Treatment and support for low-income individuals who will not be covered under the Affordable Care Act	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	é
Improve primary prevention activities	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	é
Improve collection of perfomance and outcome data	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	é
Support initiatives that address professional shortages	Please refer to the explanation under “Description of Collecting and Measuring Changes in Performance Indicator” below.	é

Footnotes:

STATE DASHBOARDS

Overview

In SFY 2011-12 DMH will work with DHCS and other organizations like the CMHPC and MHSOAC to implement several outcome dashboards; at least two that are based on SAMHSA's National Outcome Measures, and two based on state-specific performance indicators.

DMH currently maintains several dashboards that offer trending opportunities linked to certain state priorities.

Data Dashboards

Professional Shortage Areas

Through a MOU with OSHPD, DMH is able to facilitate county access to the OSHPD Dashboard. The Dashboard provides demographic information by county, neighborhood, census track and number of psychiatrists in any given county. This information is essential to any county and/or locality that wants to put together an application for federal designation as a mental health professional shortage area.

APS Healthcare, TBS and EPSDT Dashboards - Emily Q Lawsuit

In 1998, the California Department of Health Services Director, Diana Bonta, was the named defendant for the State in *Emily Q v. Bonta.*. During the course of this litigation, the defendant was changed to the California Health and Human Services Secretary who has statutory and administrative authority over the DHCS and DMH.

DMH is significantly involved in this litigation since DHCS has delegated to DMH the responsibility of administering the Medi-Cal reimbursed mental health services program, and DMH contracts with the Mental Health Plans (County governments) regarding the provision of EPSDT services. In February 2008, Federal Judge Howard A. Matz assigned a Special Master to oversee the planning and implementation process.

The Emily Q settlement team developed a Nine Point Plan that would result in increased access to and improved delivery of TBS to members of the Emily Q class. A major element of the Nine Point Plan is the development of a Web-based data dashboard that displays the on-going progress of increasing TBS utilization of all 56 MHPs within California. Key performance indicators include:

- TBS recipients as a percentage of EPSDT children with mental health services; and

- Count of TBS recipients compared to the 4% benchmark previously set.

DMH provides the data elements to APS Healthcare based on submitted claims by the MHPs. The data elements provided to APS are statistics for both statewide and individual MHPs and include data such as EPSDT eligibility and TBS recipients. The data dashboard is a way to display the MHPs' ongoing progress towards reaching a goal of 4% of TBS utilization per MHP as set by the Special Master as a part of the Emily Q Exit Plan.

In addition to the performance indicators listed above, data collected for this dashboard also includes:

- Average duration in days per TBS episode;
- Average number of contacts per TBS episode;
- Average number of minutes per TBS episode;
- Number of TBS beneficiaries;
- Number of EPSDT beneficiaries with psychiatric hospitalization; and
- Number of people eligible for EPSDT and TBS.

Mental Health Services Oversight and Accountability Commission (MHSOAC) Dashboard

The MHSOAC is currently working on a statewide dashboard of key performance indicators through an evaluation contract with UCLA to develop quarterly standardized county level reports on priority indicators for the CSS Component of the MHSA. The initial statewide draft report template was submitted to the MHSOAC on June 30, 2011. There will be a period of time for public input before the initial statewide report is finalized by March 31, 2012, and the initial county level reports will be available by June 30, 2012.

The initial priority indicators included in the statewide evaluation of the MHSA were approved by the California Mental Health Planning Council and the MHSOAC and are linked to statutory outcomes.

The following fact sheet provides information regarding the standardized county profiles of mental health priority indicators and the initial priority outcomes and indicators for CSS from UCLA regarding the recommendations for the statewide dashboard.

MHSA Community Services and
Supports (CSS)
Initial Priority Outcomes and Indicators

Outcome—What are we trying to achieve?	**Indicator**—How will progress toward outcomes be determined?
Increase number of individuals receiving public mental health services	Increase the penetration rate of those receiving services in the public mental health system
Reduce disparities in access	Improve the proportion of those served (by age, gender, race ethnicity for new clients and for FSPs) to prior proportions in the public mental health system and to California's overall demographics
Increase educational progress	Increase number of days in school for FSP participants
Increase employment	Increase in the proportion of FSP participants engaging in paid and unpaid employment
Improve housing situation	▪ Increase in days that children/youth in FSPs are living in the family or foster home. ▪ Decrease in number of days homeless ▪ Increase independence in residential status (excludes children)
Reduce justice involvement	Decrease number of arrests of FSP participants
Implement Recovery Vision	Reduce 3 and 14 day involuntary commitments.
Improve health and mental health	▪ Increase Client and Family Perception of well-being ▪ Increase proportion of FSP participants with access to primary care physician
Implement MHSA county plans	Increase the proportion of the number of individuals receiving services to the numbers of individuals estimated to be served in the MHSA county plan/update

The MHSOAC has a contract with UCLA to develop quarterly standardized county level reports on priority indicators. The initial statewide draft report template was submitted June 30, 2011, with multiple opportunities for public input. The initial statewide report will be finalized by March 31, 2012 and the initial county level reports will be available by June 30, 2012.

The CMHPC approved "Performance Indicators for Evaluating the Mental Health System, January 2010" which includes comprehensive CSS indicators after

statewide public hearings. Priority indicators were selected from this document and were approved by the CMHPC and the MHSOAC. These priority indicators were selected from available data to begin to measure progress towards statutory outcomes. The MHSOAC contracted with UCLA to develop a standardized template with documented sources and calculations for quarterly statewide and county level profiles based on the priority indicators. UCLA will evaluate the CMHPC/MHSOAC priority indicators and make recommendations for changes, as appropriate. The template, documentation and statewide reports developed by UCLA will be issued in draft for public comment prior to finalization.

IV: Narrative Plan

J. Suicide Prevention

Page 46 of the Application Guidance

Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

SUICIDE PREVENTION

California Strategic Plan on Suicide Prevention

In 2008 DMH published the *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution*. The Plan was developed through recommendations of an advisory committee consisting of experts on suicide prevention, survivors of suicide attempts and suicide loss, representatives of mental health consumer and
family members organizations, legislators, providers, crisis centers, and others. Recommendations were developed through an intensive year-long process that also included multiple points of public input.

Concurrently, DMH established the Office of Suicide Prevention (OSP) to oversee dissemination and implementation of the Plan and to serve as a statewide resource center. The Plan includes four Strategic Directions and 38 recommended actions at the state and local levels. The Plan presents detailed, California-specific data and statistics as well as information about best practices that address specific populations and settings. It identifies populations at particularly high risk of suicide, including veterans and service members, LGBTQ youth, and older adults. A copy of this Plan will be attached electronically as an Appendix.

Since its publication, the Plan has been used extensively for state and local planning purposes, and implementation of recommendations is currently under way. The OSP has launched multiple partnerships and projects to address high risk populations identified in the Plan, particularly veterans, service members, and their families. The OSP has also done extensive outreach and technical assistance to facilitate Plan implementation. Counties have actively used the Plan to design local projects.

The Plan was used as a blueprint for a $24 million statewide project on suicide prevention funded under the Mental Health Services Act which is administered by California Mental Health Services Authority (CalMHSA) , a joint powers authority of county mental health plans. Their website is located at http://calmhsa.org/ . This project was implemented in June 2011. DMH anticipates updating the Plan, which is three years old this summer, through an extensive stakeholder process and assessment of activities that have occurred since its publication within the next two to three years. Copies of the Plan are available on the DMH website at http://www.dmh.ca.gov/peistatewideprojects/SuicidePrevention.asp .

IV: Narrative Plan

K. Technical Assistance Needs

Page 46 of the Application Guidance

Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

TECHNICAL ASSISTANCE

DMH is requesting Technical Assistance in the following areas:

- Building Efficiencies with SAMHSA MHBG for local mental health plans
- Data Collection and Analysis
- Statewide Program Monitoring for SAMHSA MHBG activities and resources
- Establishment of Performance Indicators Related to Disparities
- Transitioning in to ACA (Primary Care and Behavioral Health Integration)
- Tribal Consultation

As noted earlier in this application, California State government is undergoing significant changes in structure, in effect "bringing services closer to the people." Operationally, this presents challenges as state staff must "do more with less." DMH is currently making significant alterations in its organizational chart and staffing to accommodate legislated funding changes. This process should continue throughout the current calendar year, with final changes and program movements to other departments occurring through the fiscal year. Along with the logistical department changes, DMH staff will be working on programmatic efficiencies to maintain and improve the delivery of services to individuals in the counties. As recovery from the current nationwide economic recession will be several years away yet, DMH will be focused on utilizing funding to its fullest advantage in consideration of service delivery and outcomes. DMH would like consultation around advising counties about how apply efficiencies to their use of the SAMHSA block grant.

As DMH data staff struggle with increased workload and less people to do the work, an effort has been undertaken to identify opportunities to increase efficiencies relating to data collection and analysis. DMH would benefit from cross-collaboration with other states in regards to the methods they employ to perform these tasks.

California State Government would benefit from learning about other states' methods of monitoring SAMHSA MHBG programs, whether on-site or desk-based, using technology or other reporting methods. DMH would also like to know if other states have combined block grant data collection with other programs that work alongside SAMHSA funded programs in their counties, such as Medicaid.

DMH is also requesting technical assistance on how to establish performance indicators and collect measurable data on reductions in disparities to California's diverse racial, ethnic and cultural communities and services to veterans and their families.

In addition, due to changes in the scope of Block Grant priority populations, funding options, and the focus on healthcare reform, DMH is requesting

assistance on how best to transition long-standing grant-funded county programs without disrupting services. DMH recognizes that SAMHSA is moving towards serving those populations that would otherwise be unserved or underserved after the full implementation of healthcare reform, and would like to start a dialogue on how to effectively and efficiently shift services to these populations. This includes technical assistance on implementation of our state's utilization management strategies during times of organizational and financial change.

One of SAMHSA's Block Grant Program Goals, and a priority in California, is to "coordinate behavioral health prevention, early identification, treatment, and recovery support services with other health and social services." While integration of both primary care and behavioral health services is expanding, there is much work to be done. DMH believes that a fully integrated system will provide better outcomes, more effective services, better and more efficient referrals, and reduce costs that are at an all-time high. DMH would benefit from learning more about federal efforts related to integration of care, and collaborating with both the federal government and other state governments about what works, and what does not.

DMH would like to have more information about what constitutes "tribal consultation" and what the parameters are for acceptable activity. How are other states developing this stream of feedback for tribes as well as other significant communities? Can SAMHSA provide a set of guidelines for establishing lines of communication for participation by the specific populations listed in the application instructions as well as tribes?

IV: Narrative Plan

L. Involvement of Individuals and Families

Page 46 of the Application Guidance

Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

Please see Section D, "Activities that Support the Individual in Directing the Services."

IV: Narrative Plan

M. Use of Technology

Page 47 of the Application Guidance

Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

USE OF TECHNOLOGY

MHSA-Funded Interactive Communication Technology (ICT) Projects

MHSA-funded ICT projects have included Client and Family Empowerment projects (Client / Family Access to Computing Resources, Personal Health Record Systems, Online Information Resource [Expansion / Leveraging Information-Sharing Services]) and Other Technological Needs (TN) Projects that Support MHSA Operation (Telemedicine and Other Rural / Underserved Service Access Methods, Pilot Projects to Monitor New Programs and Service Outcome Improvement, Data Warehousing / Decision Support, Imaging / Paper Conversion, etc.).

DMH staff were responsible for reviewing and approving TN Project Plans that counties submitted in order to obtain their allocated MHSA funds. Counties were required to follow departmental guidelines related to Electronic Health Record or other projects such as telemedicine. Upon project approval, counties had to submit ongoing quarterly reports and a Post-Implementation Evaluation Report (PIER) once the project was completed.

MHSA staff reviewed and approved seven telemedicine projects. Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve, maintain, or assist patients' health status. Following are summary overviews of two telemedicine projects:

<u>Merced - Expansion and Improvement of Telemedicine Project</u>

Expansion and Improvement of Telemedicine will increase access to psychiatric services for Merced County residents who live in rural or outlying communities. Consumers and family members located in Los Banos, Livingston, and other towns and unincorporated areas reported transportation-related access barriers. The telemedicine project will be able to meet the needs of isolated rural resident, psychiatrists and clinicians based in the City of Merced must spend valuable time driving to outlying areas.

Whenever possible, Merced County Department of Mental Health (MCDMH) will provide face-to-face communication between psychiatric staff and consumers. Telemedicine, particularly technology that permits video-teleconferencing consultation between providers and consumers/family members, or between multiple providers, is an acceptable alternative when face-to-face communication cannot be arranged conveniently for the consumer and provider. The expansion and improvement of the County’s telemedicine technology will significantly improve the audio and visual quality of MCDMH telemedicine services. Improved functioning will: 1) increase access to clients with transportation barriers; 2) increase psychiatric capacity; and 3) in case of psychiatric shortages, may

increase the pool of qualified candidates by facilitating work through medical technology and communications.

Trinity - County Telemedicine Upgrade

Trinity's telemedicine project will enable tremendous access in the most rural and frontier portions of the county and should be developed in concert with:

- Schools where behavioral health and other healthcare needs are often addressed;
- Jails where substance abuse, domestic violence and acute mental health needs are identified);
- Community health centers and FQHCs; and
- Critical access hospitals who will benefit from gaining access to specialty providers in the interest of earlier intervention, patient safety, coordination of care and revenue improvement.

Trinity County will provide services through videoconferencing, transmission of images, e-health tools including patient portals, remote monitoring of vital signs, continuing medical education, and nursing call centers, are all considered part of telemedicine.

Assembly Bill (AB) 100 realigns MHSA funds to be dispersed directly to the counties in order to provide management of services at the closest level of government to the people. This will facilitate the initiation and completion of ICT projects and thereby allow ICT services to be provided to the mental health beneficiary community in the most expedient timeline. Due to AB 100 and the redirection of services to the local level, DMH will no longer be reviewing TN Projects because the funding of staff to support the review process will now be directed to the county staff level.

In addition, counties will work directly with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine.

Health Information Technology (HIT), Health Information Exchange (HIEs) and Electronic Health Records (EHRs)

California has been extensively involved in HIT expansions efforts. The full implementation of HIT, defined as "the comprehensive management of health information and its secure exchange between consumers, providers, government entities and insurers," is designed to:

- Improve overall health care quality;
- Prevent medical errors;

- Reduce health care costs;
- Increase administrative efficiencies;
- Decrease paperwork;
- Expand access to affordable care; and
- Increase personal accountability and tracking of information.

Achieving electronic HIE through the application of HIT is one of the cornerstones of the overall healthcare reform strategy in California. Effective application of HIT and the implementation of interoperable HIE are key strategies to achieve the overarching goals of better health care outcomes, efficiencies in the delivery of healthcare, and strengthening emergency and disaster response preparedness.

The CHHS serves as the lead agency on HIE and HIT issues for the state. CHHS works with the California Technology Agency, the Department of Managed Health Care, the Business, Transportation, and Housing Agency and others to oversee the state's HIE and HIT related efforts. More information on this topic can be found at http://www.ehealth.ca.gov .

EHRs and Personal Health Records (PHRs) are tools that can collect, track and share past and current information about a patient's health, and play an integral role in the HIT expansion process within California. Policy makers and purchasers are both interested in the implementation of PHRs because:

- PHRs can potentially reduce costs while preserving or improving quality of care and ensuring optimal worker productivity;
- PHRs can potentially bring radical improvements in efficiency (a 2008 study by the Center for Information Technology Leaderships projected that the United States could save as much as $21 billion per year if eighty percent of the population were to use PHRs);
- PHRs promote communication (scheduling appointments, receiving testing or treatment instructions, asking questions, and renewing prescriptions);
- PHRs promote use of data, as they help to track certain diseases across populations, facilitate quality control and marketing.
- PHRs help to integrate primary care and mental health into one comprehensive record.

IV: Narrative Plan

N. Support of State Partners

Page 48 of the Application Guidance

Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

DMH intends to submit letters of support for the CMHBG from our sister agencies in concurrance with the California Department of Alcohol and Drug Program's SAPTBG submission. We anticipate providing these letters to SAMHSA as soon as they are made available.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

Page 49 of the Application Guidance

Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

IV: Narrative Plan

Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Karen Allen	State Employees	Education	1430 N St. Sacramento, CA 95814 PH: 916-322-1645 FAX: 916-327-3706	kallen@cde.ca.gov
Lana Fraser	State Employees	Vocational Rehabilitation	721 Capitol Mall, 4th Floor Sacramento, CA 95814 PH: 916-558-5416 FAX: 916-558-5402	lfraser@dor.ca.gov
Kathleen O'Meara	State Employees	Criminal Justice	501 J St. Sacramento, CA 95814 PH: 916-323-1163	kathleen.omeara@cdcr.ca.gov
Nadine Ford	State Employees	Housing	1800 3rd St. Sacramento, CA 95814 PH: 916-327-3942	nford@hcd.ca.gov
Jane Laciste	State Employees	California Department of Mental Health	1600 9th St. Sacramento, CA 95814 PH: 916-654-3135	jane.laciste@dmh.ca.gov

Michael Cunningham	State Employees	California Department of Alcohol and Drug Programs	1700 K St., 5th Floor Sacramento, CA 95814 PH: 916-322-3563	mcunningham@adp.ca.gov
Andrew Cavagnaro	State Employees	Department of Developmental Services	1600 9th St. Sacramento, CA 95814 PH: 916-651-2811	andrew.cavagnaro@dds.ca.gov
Patricia Bennet	Providers	Resource And Development Association	230 4th St Oakland, CA 94660 PH: 510-488-4344	pbennet@resourcedevelopment.net
Adam Nelson	Providers	HealthGrades	145 Corte Madera Town Center Corte Madera, CA 94925 PH: 415-460-6710	apnelson@gmail.com
Jaye Vanderhurst	Providers	Napa County Health and Human Services	2261 Elm St Napa, CA 94559 PH: 707-299-2102 FAX: 707-299-2199	
Barbara Mitchell	Providers	Interim, Inc.	P.O. Box 3222 Monterey, CA 93942 PH: 831-649-4522 FAX: 831-647-9136	
Art Martinez	Providers	University of California, Merced	5200 North Lake Rd Merced, CA 95343 PH: 775-781-0704	chumash54@yahoo.com
Stephanie Thal	Providers	Consultant	Kernville, CA 93238 PH: 760-376-4448 FAX: 760-376-6700	stevіethal.thal@gmail.com
John Ryan	Providers	Consultant	Brea, CA 92821 PH: 714-528-2498	seasane1@aol.com
Dale Mueller	Providers	Consultant	Upland, CA 91784 PH: 909-920-6046	dmueller@earthlink.net

Steven Grolnic-McClurg	Providers	Rubicon Programs	2500 Bissell Ave Richmond, CA 94804 PH: 510-231-3930	steveng@rubicon.org
Mark Refowitz	Providers	Orange County Behavioral Health Services	405 West 5th St Santa Ana, CA 92701 PH: 714-834-6023 FAX: 714-834-5506	mrefowitz@ochca.com
Jorin Bukosky	Providers	Progress Foundation	368 Fell St San Francisco, CA 94102 PH: 415-861-0828	aveadu@pacbell.net
Daphne Shaw	Providers	California Coalition for Mental Health	P.O. Box 690040 Stockton, CA 95269	dshaw1@sbcglobal.net
Beverly Abbot	Others (Not State employees or providers)	Consultant	Woodside, CA 94062 PH: 650-851-8469	bjkabbot@aol.com
Gail Nickerson	Others (Not State employees or providers)	Adventist Health	2100 Douglas Blvd Roseville, CA 95661 PH: 916-781-2000	nickergw@ah.org
Monica Wilson	Others (Not State employees or providers)	Consultant	Ontario, CA 91761 PH: 951-541-1472	monimarsh@gmail.com
Adrienne Cedro Hament	Others (Not State employees or providers)	Los Angeles County Mental Health	550 S. Vermont Ave Los Angeles, CA 90020 PH: 213-738-4395	ahament@dmh.lacounty.gov
Carmen Lee	Individuals in Recovery (from Mental Illness and Addictions)	Stamp Out Stigma	Belmont, CA 94002 PH: 950-592-2345	carmensos@aol.com
George Fry, Jr.	Individuals in Recovery (from Mental Illness and Addictions)	Advocate	Angels Camp, CA 95222 PH: 209-736-4868	beepbeeproadrnnr@aol.com
Marissa Lee	Individuals in Recovery (from Mental Illness and Addictions)	Association of Community Human Services Agencies	1200 Wilshire Blvd, Suite 203 Los Angeles, CA 90017 PH: 213-250-5030	mlee@achsa.net

Joseph P. Mortz	Individuals in Recovery (from Mental Illness and Addictions)	Advocate	Ukiah, CA 95482 PH: 707-467-9261	joemortz@hotmail.com
Shebuah Burke	Individuals in Recovery (from Mental Illness and Addictions)	Advocate	Anaheim, CA 92804 PH: 714-220-0031	writeboo@gmail.com
John Black	Individuals in Recovery (from Mental Illness and Addictions)	Stanislaus County Behavioral Health	800 Scenic Dr Modesto, CA 95351 PH: 209-558-4891	jblack@stanbhrs.org
Walter Shwe	Individuals in Recovery (from Mental Illness and Addictions)	Advocate	Davis, CA 95616 PH: 530-746-8360	walter@shwe.com
Josephine Black	Individuals in Recovery (from Mental Illness and Addictions)	Independent Living Center, Inc.	423 W. Victoria St Santa Barbara, CA 93108 PH: 805-963-0595	jblack32@cox.net
Celeste Hunter	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Family & Youth Roundtable	3434 Midway Dr San Diego, CA 92110 PH: 619-546-5852	chunter1247@cox.net
Karen Hart	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Advocate	Monterey, CA 93940 PH: 831-373-3966	khart55@sbcglobal.net
Cindy Claflin	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	United Advocates for Children and Families	2035 Hurley Way, Suite 290 Sacramento, CA 95825 PH: 916-643-1530	cclaflin@uacf4hope.org
Doreen Cease	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Los Angeles County Office of Education	La Crescenta, CA 91214 PH: 818-957-6921	doreen_cease@sbcglobal.net
Luis Garcia	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Pacific Clinics	11731 E. Telegraph Santa Fe Springs, CA 90605 PH: 626-294-1077	lgarcia@pacificclinics.org
Jennie Montoya	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	San Joaquin County Behavioral Health	1212 N. California St Stockton, CA 95202 PH: 209-468-8486	jmontoya@sjcbhs.org

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 138 of 220

Susan Wilson	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Shasta County Office of Education	424 Rosewood Dr Redding, CA 96003 PH: 530-243-7760	swilson@shastacoe.org
Glenn Hutsell	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	Stanislaus County Behavioral Health	Modesto, CA 95356 PH: 209-202-4757	ghutsell@stanbhrs.org

Footnotes:

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	39	
Individuals in Recovery (from Mental Illness and Addictions)	8	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	8	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	20	51.28%
State Employees	7	
Providers	12	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	19	48.72%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

OPPORTUNITY FOR PUBLIC COMMENT

DMH provides opportunity for public comment on the State plan through posting of the plan on the department website at http://www.dmh.ca.gov/services_and_programs/adults/SAMHSA.asp , as well as through the CMHPC pre-submission review process. Each year after the State plan is submitted to HHS it is posted on the DMH website with a notice for Public comment. The requirement for review, an overview of the State plan, the State plan, and how to submit comments are detailed on the website.

DMH is working with DHCS and ADP to post links to the State Plan and comment period on their websites. Similar outreach will be offered to the CMHPC, MHSOAC, CMHDA, and County Alcohol and Drug Program Administrators Association of California.

The CMHPC review of the State plan before submission to HHS provides stakeholder input in the development of the plan. All CMHPC members receive a copy of the plan and participate in its review. Part of the review process includes holding a publicly noticed conference call and anyone is welcome to participate. CMHPC review begins about six weeks prior to the final submission of the State Plan to SAMHSA.

The CMHPC membership also guarantees a wide variety of representation of stakeholders. CMHPC membership includes representatives of persons who are service recipients, families of individuals with mental disorders, providers of services and supports, representatives from racial and ethnic minorities, LBGTQ populations, persons with co-existing disabilities and other key stakeholders. The CMHPC is comprised of eight service recipients, eight family members, twelve providers/professionals, and several members with co-occurring substance abuse disorders. One of the members represents the LGBTQ community. Varying ethnic groups are represented; five percent are Latino, five percent are African American, seven and a half percent are Asian, and two and a half percent are Native Americans.

California will have more time to coordinate stakeholder involvement with the SAMHSA block grant becoming a 2-year grant starting 2012. In the coming years, DMH intends to expand the State Plan public comment process to facilitate comments from a wider range of stakeholders. Stakeholder groups to be included in this process are:

- Consumers, clients, and advocacy groups
- County mental health directors
- Tribal organizations
- Other social service departments

Recognizing the fact that consumer-driven policy formulation should be a top priority, DMH plans to send draft version of the State Plan for comments to mental health advocacy organizations, such as NAMI and CNMHC. These stakeholders' input is invaluable to the mental health community as they represent the very people who receive the services. Clients and consumers offer a unique perspective and can provide insights on "what works, and what doesn't."

In addition, DMH plans to distribute the draft State Plan amongst county mental health directors within California via the CMHDA. Since counties directly deliver MHBG-funded services, it is imperative not only to facilitate input and comments, but to incorporate the county perspective into the State Plan. DMH believes that cross-collaboration with counties will offer innovative ideas, help to identify service strengths and weaknesses, and help to close gaps in service delivery.

DMH is also cognizant of the fact that tribal organizations within California will play a major role in State Plan design in the coming years. That being said, DMH intends to build upon collaborative relationships with tribes to solicit input on State Plan formulation throughout the entire process. DMH will utilize its OMS unit to plan meetings and keep dialogue flowing and receive input throughout the entire planning and application process.

Lastly, DMH plans to fully cooperate with its sister departments to help the State Plan gain more of a "global" health perspective. Utilizing the knowledge of other social services departments such as Public Health, Alcohol and Drug Programs, Social Services, and Education will make the State Plan more cohesive, informational, and relevant to changing landscape of mental health and primary care delivery.

California Strategic Plan on Suicide Prevention:

Every Californian Is Part of the Solution

California Department of Mental Health

California Strategic Plan on Suicide Prevention:

Every Californian Is Part of the Solution

Based on Recommendations of the
Suicide Prevention Plan Advisory Committee

This *Strategic Plan on Suicide Prevention (Plan)* was approved by the Governor's Office of the State of California on June 30, 2008.

Arnold Schwarzenegger
Governor, State of California

Kimberly Belshé
Secretary, Health and Human Services Agency

Stephen W. Mayberg, Ph.D.
Director, California Department of Mental Health

TABLE OF CONTENTS

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 146 of 220

ACKNOWLEDGEMENTS

In September 2006, Governor Arnold Schwarzenegger directed the California Department of Mental Health (DMH), through a veto message to Senate Bill 1356 (Lowenthal), to administratively develop a statewide strategic plan on suicide prevention. The DMH and the California Health and Human Services Agency were to build on work done by the California Suicide Prevention Advocacy Network and coordinate with all interested constituency groups and state and local agencies to develop the plan by May 1, 2008. The DMH convened the Suicide Prevention Plan Advisory Committee to provide recommendations for the plan.

The Advisory Committee met over approximately nine months to craft the strategic directions and recommended actions contained in this document. In addition to the committee meetings, two stakeholder workshops were held in September 2007 to ask the public, including youth, families, and survivors of suicide attempts, to provide input on the draft plan's preliminary recommendations.

We deeply appreciate the Advisory Committee's hard work and acknowledge the personal commitment and many contributions of the individuals listed on the following pages.

STEPHEN W. MAYBERG, Ph.D.
Director, California Department of Mental Health

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 147 of 220

ALFREDO AGUIRRE
Mental Health Director and
California Mental Health Directors Association
San Diego

PATRICIA AREAN
Associate Professor of Psychiatry
University of California, San Francisco

JOHN BATESON
Executive Director
Contra Costa Crisis Center
Walnut Creek

SUSAN BELL
Outreach Coordinator
Counseling and Psychological Services
University of California, Berkeley

SAM BLOOM
Board Member
Suicide Prevention Advocacy Network
–California

LISLE MARIE BOOMER
Volunteer
Protection & Advocacy Inc.
Berkeley

MARTIN BRAGG
Director of Health and Counseling Services
California Polytechnic State University,
San Luis Obispo

DELPHINE BRODY
Director of Mental Health Services Act Client Involvement
California Network of Mental Health Clients

JOHN BUCK
Chief Executive Officer
Turning Point Community Programs
Sacramento

RICK CAWTHORN
Mental Health/Addiction Therapist
Hoopa Valley Tribal Council Division of Human Services

MARK CHAFFEE
President
Suicide Prevention Advocacy Network
–California

DIANA E. CLAYTON
Vice President
National Alliance on Mental Illness,
Shasta County

BARBARA COLWELL
Psychiatric Social Worker
Los Angeles Unified School District

CAROLE LEE CORY
Assistant Director, Community Relations
California Department of Aging

REBECCA CRAIG
Field Representative
Department of Corrections and Rehabilitation

JOE CURREN
Executive Director
Redwood Coast Seniors
Fort Bragg

KITA CURRY
President and Chief Executive Officer
Didi Hirsch Community Mental Health Center and California Council of Community Mental Health Agencies
Los Angeles

LETICIA GARCIA
Legislative Aide
Office of State Senator Alan Lowenthal

LUIS GARCIA
Corporate Director
Latino Program Development,
Pacific Clinics, Arcadia, and
California Mental Health Planning Council

ALBERT GAW
Professor of Psychiatry
University of California, San Francisco, and
Medical Director, Quality Management
San Francisco Community Behavioral Health Services

JANET GOREWITZ
Licensed Psychologist

LEANN M. GOUVEIA
Executive Director
Fresno Survivors of Suicide Loss, Inc.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 148 of 220

MARY HAYASHI
California State Assembly Member and
Mental Health Services Oversight and
Accountability Commissioner

MAJOR STEVEN KEIHL
Director of Mental Health
California National Guard

MORRIS LAWSON II
Student, Intern Therapist
Monrovia

TOM LEE
Deputy Director
California Department of Social Services

SEPRIEONO LOCARIO
Prevention Coordinator
Native American Health Center
Oakland

VICKIE MAYS
Professor of Psychology/Health Services
University of California
Los Angeles

ED MORALES
Chief Psychiatrist
Department of Corrections and
Rehabilitation
Division of Juvenile Justice

MARIA PEÑA
Student Services Coordinator
Mira Costa College
Disabled Students Programs and Services
Oceanside

MICHAEL PINES
Mental Health Consultant
Los Angeles County Office of Education

DEDE RANAHAN
Mental Health Services Act Policy
Coordinator
National Alliance on Mental Illness,
California

CHARLES ROBBINS
Executive Director
The Trevor Project
West Hollywood

CHAPLAIN MINDI RUSSELL
Executive Director and Senior Chaplain
Law Enforcement Chaplaincy
Sacramento

RUSTY SELIX
Executive Director
California Council of Community
Mental Health Agencies

ELIZABETH (BETSY) SHELDON
Education Programs Consultant
California Department of Education

CLYDE STEELE
Manager
California Department of Alcohol and Drug
Programs
Health Insurance Portability and
Accountability Act Compliance Project

ROGER TRENT
Chief
Injury Surveillance and Epidemiology
Section California Department of Public
Health

ALICE TRUJILLO
Supervisor
California Department of Alcohol and Drug
Programs
Co-Occurring Disorders Unit

BILLEE WILLSON
Program Planner
Sacramento County Department of Health
and Human Services

MICHELLE WOODS
Staff Mental Health Specialist
Mental Health Services Oversight and
Accountability Commission

TINA TONG YEE
Former Director
San Francisco Community Behavioral Health
Office of Cultural Competence and Client
Relations

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 149 of 220

SUPPORT TO THE COMMITTEE AND PLAN

The following individuals provided support for the Advisory Committee and development of the Plan

Consultants

STEVE SHIPPEN
California Department of Public Health
Health Information Strategic Planning
Planning and Data Analysis Section

LANNY BERMAN
Executive Director
American Association of Suicidology

JOHN DRAPER
Project Director
National Suicide Prevention Lifeline

DAVID LITTS
Associate Director
Suicide Prevention Resource Center

RICHARD MCKEON
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

Facilitation Team

Center for Collaborative Policy
California State University, Sacramento

SUSAN SHERRY
Executive Director

DEB MAROIS
Lead Facilitator

SAM MAGILL
Assistant Facilitator

Plan Support

JANICE LOWEN AGEE
Editor

SHARLEEN DOLAN
Plan Consultant

PEGGY FISH
California State Library

JENNIFER MCLAUGHLIN
California State University, Sacramento

DMH Staff

EMILY NAHAT
Chief
Prevention and Early Intervention Section

BARBARA MARQUEZ
Mental Health Program Supervisor

BEVERLY WHITCOMB
Mental Health Program Supervisor

Lead Project Staff:

SANDRA BLACK

ORLANDO FUENTES

Other staff who contributed:

CIELO AVALOS

NICHOLE DAVIS

LINDSAY HAMASAKI

MICHELLE LAWSON

BERTHA MACDONALD

SONIA MAYS

DIANE STIDGER

CAITLIN VISCARDI

JUSTIN WHITCOMB

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 150 of 220

INTRODUCTION

The statistics about suicide are alarming. Suicide is the tenth leading cause of death in California. Every year approximately 3,300 Californians lose their lives to suicide. More suicide deaths are reported in our state than deaths caused by homicides. On average, nine Californians die by suicide every day. Suicide and suicidal behaviors occur among all age groups and across all socioeconomic, racial, and ethnic backgrounds.

> *"On average nine Californians die by suicide every day."*

The causes of suicide are complex and include an array of biological, psychological, social, environmental, and cultural risk factors. Too often, there is lack of coordination between service systems and providers and a lack of knowledge about how to recognize the warning signs of suicide. For far too long, suicide has been viewed as a taboo subject. Fear of stigma and discrimination surrounding suicide can be so pervasive that it often deters people from seeking help.

Suicide is a devastating tragedy in terms of the lives lost and the emotional heartbreak that family members and other loved ones endure. This tragedy is even more distressing because suicide deaths are preventable.

Traditionally, suicide has been considered primarily a concern of the mental health system, largely due to the connection between mental illnesses, such as depression, and the elevated risk of suicide. However, in 2001, the President's New Freedom Commission called for a change that would place mental health

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 151 of 220

into the context of the broader public health system. The transformed system would provide quality care for those in need, but it would also promote resiliency, recovery, and health.

In response to this change and in combination with other events, Governor Arnold Schwarzenegger in 2006 charged the Department of Mental Health (DMH) with the development of a strategic plan on suicide prevention. The DMH embarked upon this work in partnership with the Suicide Prevention Plan Advisory Committee composed of mental health experts, advocates, providers, researchers, and representatives from various nonprofit and government agencies. The Advisory Committee also included other important voices—survivors of suicide attempts and suicide loss.

The *California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution* (Plan) is built upon the vision that a full range of strategies, starting from prevention and early intervention, should be targeted to Californians of all ages, from children and youth to adults and older adults. To effectively reduce suicides and suicidal behavior, communities need prevention services to promote health and address problems long before they become acute, as well as a coordinated system of services to effectively respond to crisis situations.

This Plan serves as a blueprint for action at the local and state levels. The Plan is intended to guide the work of policy makers, program managers, providers, funders, and others in bringing systems together to better coordinate their efforts, and to enhance needed prevention and intervention services as well as postvention, or services provided after a suicide or suicide attempt that offer follow-up care for survivors.

The Plan consists of four major parts:

- Part I presents information about suicide's impact and magnitude from different sources and different perspectives.
- Part 2 describes successful and promising strategies, practices, and policies that have been used to prevent suicide.
- Part 3 provides the Advisory Committee's recommended actions to reduce suicide deaths and the incidence of suicidal behaviors in California. Many of the recommendations require a long-term effort, while others can be implemented more quickly.
- Part 4 lists the next steps for local and state action.

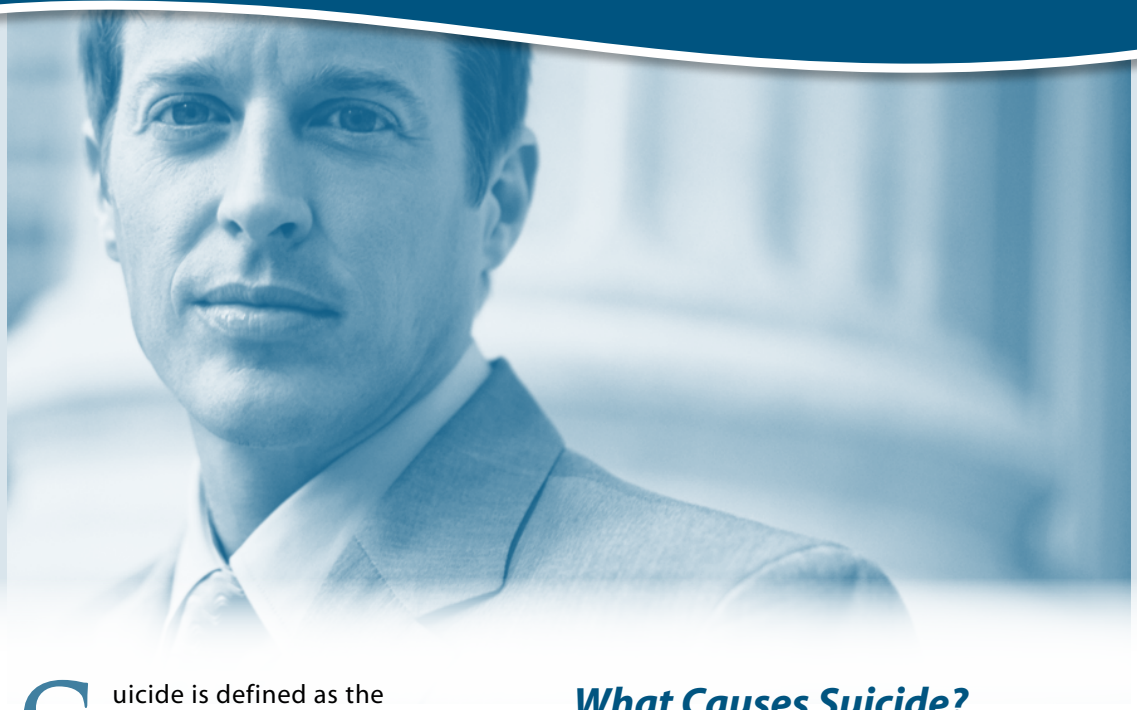
An Executive Summary of the Plan is also available that provides a brief overview of Parts 1 and 2 as well as the complete list of strategic directions, recommended actions, and next steps.

This Plan should be viewed as a dynamic document that will be periodically reviewed and revised to reflect evolving needs in California. Over time, it is anticipated that the full spectrum of strategies, from prevention through intervention, will be more comprehensively addressed.

Suicide prevention must be a priority in our state. While many challenges lie ahead in carrying out this work, tremendous opportunities also exist. With thousands of lives at stake each year, every Californian needs to be part of the solution.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 152 of 220

PART 1: THE PROBLEM AND THE CHALLENGE



Suicide is defined as the intentional taking of one's own life.[a] It is the "final and most severe endpoint" along a continuum of self-harming behaviors.[1] The broader term of suicidal behavior also includes self-inflicted, potentially injurious behaviors.[2] Clearly, it is important to monitor the whole range of self-harmful or injurious behaviors because they may indicate an increased risk of suicide in the future. Suicides may be hidden from vital statistics data. They may include a lethal overdose of prescription or illegal drugs, single car collisions with a fixed object, or incidents when an individual engages in a life-threatening behavior to the degree that it compels a police officer to respond with deadly force.

What Causes Suicide?

The causes of suicide are complex and vary among individuals and across age, cultural, racial, and ethnic groups. The risk of suicide is influenced by an array of biological, psychological, social, environmental, and cultural risk factors (Table 1).

Many people who attempted or completed suicide had one or more warning signs before their death (Table 2). While warning signs refer to more immediate signs or symptoms in an individual, risk factors for suicide are generally longer-term factors that are associated with a higher prevalence of suicide in the population.[3] Recognition of warning signs has a greater potential for immediate prevention and

NOTES

[a] Assisted suicide is beyond the scope of this Plan.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 153 of 220

Table 1: Risk Factors for Suicide.

Bio-psycho-social Risk Factors

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders
- Alcohol and other substance abuse disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relationship or social loss
- Easy access to lethal means
- Local clusters of suicides that have a contagion influence

Sociocultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing health and mental health services and substance abuse treatment
- Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution to a personal dilemma)
- Exposure to suicide through the media and the influence of others who have died by suicide

Source: Suicide Prevention Resource Center

Table 2: Warning Signs of Suicide.

Signs of acute suicidal ideation:

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves, e.g., seeking access to pills, weapons, or other means
- Talking or writing about death, dying, or suicide if this is unusual for the person

Additional warning signs:

- Expressing feelings of hopelessness
- Showing rage or anger or seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Indicating a feeling of being trapped – like there is no way out
- Increasing use of alcohol or drugs
- Withdrawing from friends, family, or society
- Experiencing anxiety, agitation, inability to sleep, or sleeping all the time
- Showing dramatic changes in mood
- Expressing no reason for living, or no sense of purpose in life

Source: Suicide Prevention Resource Center

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 154 of 220

intervention when those who are in a position to help know how to appropriately respond.

Feelings of hopelessness and an inability to make positive changes in one's life are two consistent psychological precursors to suicidal behaviors.[4,5] Many of those who die by suicide are described by family or friends as having been depressed or as having problems with a current or former intimate partner.

Trauma has a significant impact on suicide risk across the life span. A survey of over 17,000 patients at a health clinic in San Diego found that a history of adverse childhood experiences was associated with a significant increase in the prevalence of attempted suicides.[6] For example, individuals reporting that their parents had separated or divorced were twice as likely to have attempted suicide, and those who were emotionally abused as children were five times as likely to have attempted suicide. For each additional adverse experience, the risk of attempted suicide increased by about 60 percent. This study also found a high prevalence of depression and substance abuse, suggesting that a history of adverse childhood experiences is associated with a host of negative outcomes.

What Are the Protective Factors Against Suicide?

Protective factors can reduce the likelihood of suicide by counterbalancing some of the risk factors (Table 3).

Examining populations with lower suicide rates can help understand potential protective factors and focuses for prevention strategies. Social (including religious), political, and economic factors may help explain different rates of suicide between countries.[7] According to the World Health Organization, the highest suicide rate in the world is in Hungary (66.0) and the lowest is in Mexico (2.5).[b] Differences in rates of depressive disorders, alcohol consumption, proportion of older adults, levels of social isolation, and religiosity may all play a role in the rate of suicide.[7]

In the United States (U.S.), suicide rates among African American women, particularly in middle age, are very low.[8] In California, the lowest suicide rate is among Latinos between 55 to 64 years of age.[9] Sociocultural differences between population groups and between

Table 3: Protective Factors Against Suicide

- Effective clinical care for mental, physical, and substance abuse disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self-preservation

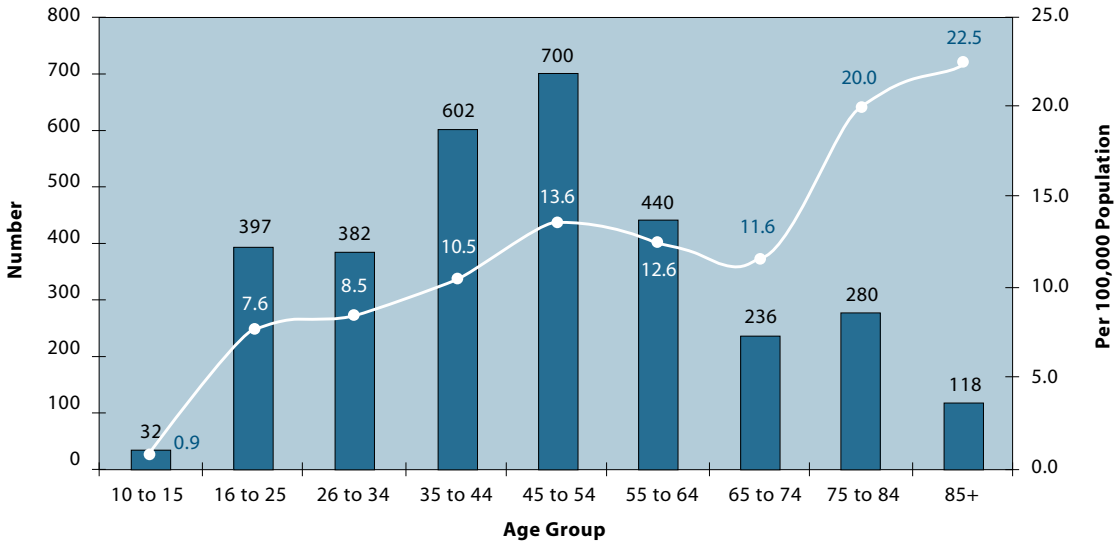
Source: Suicide Prevention Resource Center

NOTES

[b] These data should be interpreted cautiously, as they are compiled from various sources and studies. They may have employed different criteria and methods, which may result in under-reporting of actual suicide deaths.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 155 of 220

Figure 1. Suicide Death Rates and Number of Deaths in California by Age, 2005.



Source: California Department of Public Health

individuals, including social connectedness, family relations, marital status, parenthood, and participation in religious activities and beliefs (including negative moral attitudes toward suicide), may all be important underlying factors.[7]

> *"The rate of suicide increases significantly with advanced age."*

Who Dies by Suicide?

According to data from the CDPH, the age-adjusted[c] rate of suicide within the general population of the state is 8.8 per 100,000.[d] The most recent California County Health Status Profiles report indicates that the highest average number of suicide deaths from 2003 to 2005 was in Humboldt County (20.0), and that Los Angeles County had the lowest rate (7.2). In 2004, over 16,000 individuals were hospitalized for self-inflicted injuries in California (46.0).[9]

Age

The *rate* of suicide increases significantly with age (Figure 1). In California, adults over the age of 85 have the highest suicide rate in the state, at 22.5.[9] However the largest *numbers* of suicide deaths occur in the age range of 45 to 54, as shown in Figure 1. Of the 3,187 individuals who died by suicide in 2005, over 40 percent (1,302) were adults between 35 to 54 years of age.

Depression and chronic illness are significant risk factors for suicide among older adults.[10] In addition to heightened suicide risk, depression is linked to multiple adverse health outcomes, including premature mortality and diminished quality of life.[11] Depression rates are particularly high among older adults receiving

NOTES

[c] An age-adjusted rate allows for comparisons between groups with different age distributions.

[d] Throughout this report, all references of suicide rates are per 100,000 population.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 156 of 220

Table 4. Ten Leading Causes of Death, California 2005, All Races, Both Sexes (County of Residence)

Rank	Age Group												
	<1	01-05 [a]	06-09 [b]	10-15	16-25	26-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 684	Unintentional Injury 222	Unintentional Injury 89	Unintentional Injury 191	Unintentional Injury 1,563	Unintentional Injury 1,203	Unintentional Injury 1,744	Malignant Neoplasms 4,936	Malignant Neoplasms 9,323	Malignant Neoplasms 12,953	Heart Disease 18,998	Heart Disease 25,367	Heart Disease 64,689
2	Short Gestation 453	Congenital Anomalies 76	Malignant Neoplasms 47	Malignant Neoplasms 74	Homicide 985	Homicide 577	Malignant Neoplasms 1,562	Heart Disease 3,499	Heart Disease 6,189	Heart Disease 8,991	Malignant Neoplasms 16,422	Malignant Neoplasms 8,528	Malignant Neoplasms 54,613
3	Maternal Pregnancy 174	Malignant Neoplasms 62	Congenital Anomalies 16	Homicide 73	Suicide 397	Malignant Neoplasms 409	Heart Disease 1,164	Unintentional Injury 2,019	Unintentional Injury 1,191	Chronic Low Resp. Dis. 2,622	Chronic Low Resp. Dis. 5,139	Cerebro-Vascular 6,431	Cerebro-Vascular 15,551
4	SIDS 151	Homicide 37	Chronic Low Resp. Dis. 7	Congenital Anomalies 39	Malignant Neoplasms 282	Suicide 382	Suicide 602	Liver Disease 1,116	Diabetes Mellitus 1,173	Cerebro-Vascular 1,986	Cerebro-Vascular 5,015	Alzheimer's Disease 4,920	Chronic Low Resp. Dis. 13.167
5	Placenta, Cord, Membranes 90	Heart Disease 19	Heart Disease 7	Suicide 32	Heart Disease 118	Heart Disease 280	HIV 468	Chronic Low Resp. Dis. 703	Chronic Low Resp. Dis. 1,140	Diabetes Mellitus 1,678	Diabetes Mellitus 2,360	Chronic Low Resp. Dis. 3,722	Unintentional Injury 10,926
6	Neonatal Hemorrhage 89	Influenza & Pneumonia 19	Homicide 6	Heart Disease 25	Congenital Anomalies 56	HIV 97	Liver Disease 420	Suicide 700	Chronic Low Resp. Dis. 1,046	Influenza & Pneumonia 772	Alzheimer's Disease 2,347	Influenza & Pneumonia 3,680	Alzheimer's Disease 7,694
7	Resp. Distress 89	Chronic Low Resp. Dis. 8	Influenza & Pneumonia 6	Chronic Low Resp. Dis. 9	Complicated Pregnancy 29	Liver Disease 57	Homicide 385	Diabetes Mellitus 660	Liver Disease 1,039	Unintentional Injury 705	Influenza & Pneumonia 2,291	Diabetes Mellitus 1,500	Diabetes Mellitus 7,679
8	Bacterial Sepsis 68	Chronic Low Resp. Dis. 6	Benign Neoplasms 4	Benign Neoplasms 8	Chronic Low Resp. Dis. 26	Diabetes Mellitus 55	Chronic Low Resp. Dis. 267	HIV 451	Suicide 440	Liver Disease 682	Unintentional Injury 1,035	Hypertension 1,351	Influenza & Pneumonia 7,537
9	Unintentional Injury 65	Perinatal Period 6	Chronic Low Resp. Dis. 3	Influenza & Pneumonia 7	Diabetes Mellitus 25	Congenital Anomalies 54	Diabetes Mellitus 219	Chronic Low Resp. Dis. 391	Influenza & Pneumonia 369	Nephritis 436	Parkinson's Disease 883	Unintentional Injury 887	Liver Disease 3,819
10	Intrauterine Hypoxia 62	Meningitis 5	Diabetes Mellitus 1	Diabetes Mellitus 6	HIV 15	Chronic Low Resp. Dis. 51	Influenza & Pneumonia 107	Viral Hepatitis 254	Nephritis 307	Hypertension 388	Hypertension 882	Athero-sclerosis 845	Suicide 3,188

Source: California Department of Public Health

[a] Septicemia also ranked 10th. [b] Liver Disease, Meningococcal Infection, Perinatal Period, and Septicemia also ranked.

in-home care or living in institutions and among those with chronic diseases such as asthma, chronic obstructive pulmonary disease, arthritis, and heart disease.[11]

Older adults are becoming an increasing proportion of the state's growing population, particularly as the baby boomers approach age 65. In 2000, the population of people over the age of 65 was over 3.6 million; in 2010 it is projected to be over 4.4 million; and in 2020, it may exceed 6.3 million.[12] Thus, it is becoming increasingly important to pay attention to the high rates of suicide among older adults.

Another way to understand the data is to consider leading causes of death in California (Table 4). Although the rate of suicide among older adults is high, suicide is not one of the ten leading causes of death among adults aged 65 and older. Among youth and young adults between 16 to 25 years of age, suicide is the third leading cause of death.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 157 of 220

Table 5. Age-Adjusted Suicide Death Rates by Race/Ethnicity and Sex, California, 2005.

Race/Ethnicity	Males	Females
Whites	19.3	5.9
African Americans	9.1	2.9
Asians	7.9	2.9
Latinos	7.5	1.4
2+ races*	5.9	3.3
All Races Combined	14.1	4.0

Source: California Department of Public Health **This rate is considered statistically unreliable.*

Nationally, more teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, strokes, pneumonia, influenza, and chronic lung diseases combined.[13] Among specific groups, including females from 10 to 19 years of age and males between 15 to 19 years of age, national data indicate an increase in suicide rates in recent years.[14]

Data from a University of California (UC) survey illustrates the prevalence of suicidal behavior among young adults. Among students participating in the survey, nine percent reported serious suicidal ideation, and up to 80 percent of those had not received mental health services.[15] The incidence of suicidal behavior, including attempts, the number of students taking psychotropic medications, and the number of mental health and crisis visits to student health centers increased significantly between 2000 and 2005. The students identified at the highest risk for completing suicide included graduate students; gay, lesbian, bisexual, transgender, and questioning (GLBTQ) students; international students; and racially and ethnically underrepresented students.

Sex

In California, males are three times more likely to die by suicide than females.[9] After the age of 14, rates of suicide are significantly higher among males regardless of age, race, or ethnicity (Table 5).

However, it is important to note that women attempt suicide three times as frequently as men and are more likely to be hospitalized for self-inflicted injuries, primarily from poisoning or hanging.[9] Sixty percent of hospitalizations for self-inflicted injuries are among females. Several studies have reported that women are both more likely than men to attempt suicide and also to have a history of sexual abuse.[6,16,17]

The difference between the sexes in suicidal behavior begins to emerge in adolescence (Table 6). Surveys of eighth grade students in California, Arizona, Nevada, and Wyoming found that girls were more likely to report suicidal ideation and attempts than boys and that girls were also more likely to feel like they had less control over their environment.[5]

In addition to mortality rates, the public health burden of suicide is also measured in terms

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 158 of 220

Table 6. Suicide Death Rates by Age and Sex, California, 2005.

Age Groups	Rates among males	Rates among females
All Ages	14.1	5.9
1-4	-	-
5-14	0.4	0.2
15-24	10.9	2.6
25-34	13.0	3.8
35-44	15.8	4.9
45-54	19.8	7.5
55-64	19.3	6.3
65-74	19.5	4.9
75-84	39.6	6.1
85 and older	53.5	6.6

Source: California Department of Public Health

of years of potential life lost and value of lost earnings. One study that used this approach found that middle-aged men contribute disproportionately to the burden.[19] The study suggested that concerns around stigma and help-seeking behavior may contribute to this problem among men.

Race and Ethnicity

Rates of suicide differ significantly among racial and ethnic groups (Figure 2). The most recent available data in California indicate that in 2005 Whites had the highest rate of suicide followed by Native Americans (American Indians), Pacific Islanders, African Americans (Blacks), Asians, people identifying as two or more races, and Latinos.[9] These rates vary among counties. It is important to note that even a small increase in the number of deaths can dramatically increase the rate in population groups that are relatively small in number, as evidenced by the increase in the suicide rate among Pacific Islanders in 2003 (Figure 2).

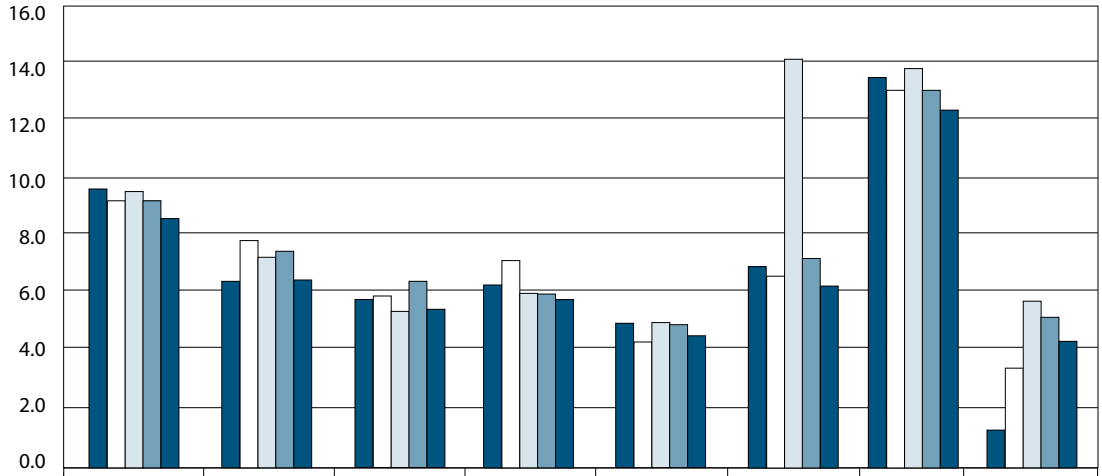
California data are consistent with national data, which indicate that Whites account for 84 percent of all suicide deaths.[20] However, despite the very high suicide rates among White males, few prevention programs target this demographic. This group is also one of the least likely to seek mental health treatment.[21]

Historically, African Americans have had lower rates of suicide than other racial and ethnic groups. However, national studies have noted that the suicide rate among African American males under the age of 35 has increased significantly over the last two decades, particularly among young men in the northern and western states.[22]

Among Latinos, suicide attempts are most prevalent in young females under the age of 18; data from the national Youth Risk Behavior Surveillance study of youth in grades seven, nine, and eleven found

AGE-ADJUSTED DEATH RATE

Figure 2. Age-adjusted Suicide Death Rates By Race/Ethnicity, California Residents, 2001-2005.



	Total	American Indian*	Asian	Black	Latino	Pacific Islander*	White	Two or More Races*
2001	9.7	6.5	5.6	6.1	4.9	7.0	13.4	1.3
2002	9.4	7.9	5.7	7.0	4.3	6.8	13.0	3.5
2003	9.7	7.4	5.2	5.9	4.9	14.3	13.7	5.9
2004	9.4	7.6	6.3	5.8	4.8	7.3	13.0	5.3
2005	8.8	6.6	5.3	5.7	4.4	6.3	12.3	4.5

*Includes unreliable rates for American Indian, Pacific Islander, and Two or More Races.

Source: California Department of Public Health

that more Latina students, nearly one quarter, reported suicidal ideation and behaviors than their White or African American female peers.[23,24]

Limitations of Race and Ethnicity Data

It is important to note that the suicide rates for American Indians and Pacific Islanders are considered unreliable due either to small population size or the relatively small number of events that are reported (less than 20 per year). However, national data indicate that American Indian and Alaska Native youth are at disproportionately high risk of suicide compared to non-Native youth. Suicide is the leading cause of death among American Indians and Alaskan Natives between 15 and 24 years of age, and from 1999 to 2004, young men in this population had a higher suicide rate (27.99) than any other racial and ethnic group of the same age.[20]

The discrepancy between the low number of reported incidents of suicide among certain racial/ethnic groups in California and what is known from national data suggest the need for improved research and surveillance activities that target these groups. It is critical to understand that suicide prevention research and surveillance activities need to determine whether there may be a significant difference between California's population and that in other states, or whether data reporting and analysis need to be strengthened for all population groups that may currently be underreported.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 160 of 220

Mental Illness

The National Violent Death Reporting System found that nearly half of suicide cases involve at least one documented mental health diagnosis.[10] It is estimated that as many as 90 percent of individuals who died by suicide had a diagnosable mental illness or substance abuse disorder.[25] Certain psychiatric diagnoses increase the risk of suicide substantially. Among individuals diagnosed with a major mood disorder (a spectrum that includes major depression and bipolar disorder), up to 20 percent die by suicide.[26] The risk tends to be highest among those who have frequent and severe recurrences of symptoms.[27]

Suicide is the leading cause of death among individuals with schizophrenia. Nearly 6 percent complete suicide, with most suicide deaths occurring early in the illness, and up to 40 percent attempt suicide at least once.[28,29] Co-occurring substance and alcohol abuse exacerbates the risk of suicide. In one national study, individuals diagnosed with major depressive disorder that used drugs or engaged in binge drinking were significantly more likely to report suicidal thoughts and to attempt suicide than those with major depressive disorders who did not abuse alcohol or drugs.[30]

Issues of stigma and discrimination related to mental illness and suicide may negatively impact accurate identification and reporting of suicide deaths. Ascertaining suicidal intent in determining cause of death is often a challenge. This challenge can be exacerbated by concerns about the impact of a determination of suicide on the families and others who lost a loved one and by concerns about confidentiality, particularly in small communities.

Criminal Justice System Involvement

Nationally, the number of individuals with mental illness who are in jails and prisons is higher than those that are in psychiatric hospitals.[31] More than half of all prison and jail inmates have a mental illness. This rate is three times that of the general population.[32]

Suicide is the third leading cause of death in California prisons.[144] Like other prison systems nationally, suicide deaths in California's prisons are predominantly among White males.

> *"Suicide is the third leading cause of death in California prisons."*

The U.S. Department of Justice reports that between 1994 and 2003, suicide was the second leading cause of death for individuals in custody.[33] Nationally, suicide accounted for 32 percent of local jail inmate deaths between 2000 and 2002. Suicide rates in local jails were three times that in state prisons. Violent offenders were nearly three times more likely to die by suicide than other inmates in jails.

In both jails and prisons across the country, White inmates have significantly higher rates of suicide than other races.[33] In prisons, male and female inmates die by suicide at similar rates. However, in jails, men are over 50 percent more likely to die by suicide than females. Finally, 80 percent of suicides occur within the cell.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 161 of 220

In prisons, the periods of highest risk for suicide are during the first month of incarceration and the first few weeks after release.[34,35] Nearly half of jail suicides occur within the first week of custody. Almost one quarter of these are on the date of admission or the following day.[33]

One study found that in 40 percent of the 196 intimate partner homicide cases in California that occurred in 1996, the perpetrator also completed suicide.[36] In these cases, the use of a gun and a perpetrator who was a White male were both significant predictors that the perpetrator would also complete suicide. Among older people who died by intimate partner homicide-suicide, the reasons were typically related to poor health or financial concerns.

Veterans

An analysis of data from national health surveys and the National Death Index from the middle 1980s to 1990s found that male veterans were twice as likely to die by suicide as the general male population, especially those who were White, less educated, and had physical disabilities.[37] Data collected prior to the Iraq War estimated that suicide rates among veterans currently using Veterans Affairs (VA) facilities were 45.0 per 100,000 among those over the age of 65, and as high as 83.0 per 100,000 for those under age 65.[38] Extrapolating from more recent national data, the VA estimates that there are 1,000 suicides per year among veterans receiving care through the VA health care system and as many as 5,000 per year among all veterans.[38] Some of the groups at highest risk include those with severe mental illnesses, combat-related post-traumatic stress disorder (PTSD), traumatic brain injury, traumatic amputation or disfigurement, military sexual trauma, and spinal cord injuries.

> *"Male veterans are twice as likely to die by suicide as the general male population."*

A study of patients in the VA health care system found that among veterans receiving treatment for depression, the rate of suicide was seven to eight times that of their counterparts in the general population (a rate of 88.25 among veterans versus a rate of 13.5 among the general population in 2004).[39] This study found that several trends in suicide deaths among veterans are different from those found in the general population. For example, the risk is higher among younger, rather than older, individuals, particularly in the presence of conditions such as PTSD. Furthermore, the relative suicide rates of male and female veterans are not as far apart as those in the general population.

Surveys of military personnel stationed in Iraq and Afghanistan indicate that as many as 17 percent met the criteria for major depression, generalized anxiety, or PTSD.[40] This is significantly higher than the rates among the general population. Of those personnel, less than 40 percent sought mental health care, and many reported being concerned about stigma and discrimination because of their mental health problems.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 162 of 220

The danger of untreated mental illness among veterans is illustrated by the fact that among populations with high rates of suicide - older adults, those with a mental illness or substance abuse disorder, and those who are homeless – a large number are also veterans. The VA estimates that approximately one-third of all adults who are homeless are veterans.[41] Nearly half of homeless veterans have a mental illness, 70 percent suffer from alcohol or other drug abuse, and 56 percent are African American or Latino.[41] The number of homeless Vietnam-era veterans is greater than the number that died in that war. To address this problem and to prevent it from growing in the future, California's suicide prevention planning must take into account the unique needs of veterans who have recently, or will soon be, returning from the active field of war.

Homeless Individuals

Although individuals who are homeless often meet many of the criteria for elevated suicide risk, such as serious and untreated mental illness, social isolation, poverty, and substance abuse, the data about suicide in this population is limited.[42] Collecting accurate data about suicidality among individuals who are homeless presents a methodological challenge for many of the same reasons that put them at higher risk.

The Access to Community Care and Effective Services and Supports (ACCESS) program, a national Substance Abuse and Mental Health Services Administration (SAMHSA) demonstration project, served over 7,000 individuals experiencing serious mental illness and chronic homelessness at 18 sites nationally. Among a sample of these individuals, over 50 percent reported that they had attempted suicide, over 25 percent reported an attempt that resulted in hospitalization for their injuries, and eight percent reported an attempt in the previous 30 days.[43] The lifetime prevalence of suicidal ideation was 66 percent. Younger age, co-occurring substance abuse, and presence of psychiatric symptoms were all significantly associated with suicide attempts. Those who reported a recent attempt also reported higher rates of inpatient mental health care utilization.

Other studies have also found that individuals who are homeless longer than six months may be at particularly high risk of suicide.[44] Furthermore, suicide rates are highest among individuals 30 to 39 years old, although co-occurring substance abuse significantly increases the risk among older individuals.[45] Among homeless and runaway youth, factors such as depression, history of physical and sexual abuse, and having a friend who attempted suicide may all contribute to an increase in suicide risk.[46]

Immigrants

Several factors may influence the rates of suicide among certain groups, including accessibility of mental health services, especially services that are culturally and linguistically appropriate. Different cultural attitudes about suicide and mental health may also play an influential role in the willingness to seek help for mental health problems. For specific immigrant and refugee populations, factors related to acculturation and family conflict may play an important role.[24]

Riverside County is one of the fastest growing counties in California, primarily due to immigration. One study examined over 100,000 death certificates from first generation White immigrants who had died between 1998 and 2001.[47] There was

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 163 of 220

significantly higher mortality from suicide among non-Hispanic White immigrants (including those born in Europe, the Middle East and North Africa), than U.S. born individuals of the same ethnicity.

Another study of coroner case records from the same time period examined some of the factors associated with the higher suicide risk among immigrants. Those at highest risk of suicide were more recently arrived; divorced, separated, or widowed; male; middle aged or older; and White.[48]

Rural Populations

Rural states have the highest rates of suicide in the country, particularly among adult and older adult males and youth. One study found that among people diagnosed with bipolar disorder, those who live in rural areas have higher rates of suicide attempts than their urban counterparts.[49] Possible contributing factors to this higher rate include the availability and quality of mental health services, increased impact of stigma due to reduced anonymity in smaller communities, higher poverty rates, and the larger percentage of older adults in the population.[49,50]

One study compared the suicide rates in urban and rural counties in California with the per capita number of health (licensed physicians) and mental health providers in those counties.[51] The study confirmed that the rates of suicide were higher in rural counties, and also that the rate of suicides by firearm were higher the more rural the county. However, the rate of suicide was not correlated with the per capita number of health and mental health providers in the counties. This study was not able to address the issue of the quality and accessibility of appropriate services in rural areas. More research needs to be done to determine if issues of quality and accessibility play a role in the higher suicide rates in rural areas.

> *"Lesbian, gay, and bisexual individuals, particularly adolescents and youth, have significantly higher rates for suicidal behavior."*

Sexual Minority Populations

Data from multiple national studies (including the National Longitudinal Study of Adolescent Health, National Lesbian Health Care Survey, National Latino and Asian American Survey, and the Urban Men's Health Study) have demonstrated that lesbian, gay, and bisexual individuals, particularly adolescents and young adults, have significantly higher rates of suicidal ideation and suicide attempts than their heterosexual counterparts.[52,53,54,55,56]

Research within California confirms the national data:

- In a survey of over 2800 men who either identified as gay or bisexual or as having had sex with other men in four U.S. cities, including Los Angeles and San Francisco, over 20 percent of respondents had made a suicide plan and another 12 percent had attempted suicide at least once, typically before age 25.[57] This represents a three-fold increase in risk among gay and bisexual men compared to men in the general population.

- Ten percent of respondents in a survey of over 500 Los Angeles County men between ages 18 to 24 who identified as gay, bisexual, or questioning,

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 164 of 220

or having had sex with a man, reported having seriously considered suicide.[58] This group was also characterized by low rates of access to health care and health insurance coverage.

- A San Francisco survey of over 523 transgender individuals found that nearly one-third of the respondents had attempted suicide.[59] This study is unique in that it identified gender discrimination and physical victimization as independent risk factors for suicide attempts.

> *"Suicide is the second leading cause of postpartum maternal deaths."*

Coping with stigma and discrimination based on sexual orientation can be a particularly challenging issue for adolescents and young adults. A survey of over 1,700 California youth ages 12 to 18 years found that those who identified as lesbian, gay, or bisexual were at elevated risk for a range of health and mental health problems, especially those youth who reported being less comfortable with or uncertain about their sexual orientation.[60]

Social support in a community of peers is especially important to this vulnerable population, especially when family and school environments are stressful. One longitudinal study of lesbian, gay, and bisexual youth between ages 15 to 19 in the New York City area found that the strongest predictive factors of suicide risk were a history of parental psychological abuse and more gender atypical behavior in childhood, especially among males.[54]

Among gay or bisexual men, factors associated with higher risk included a perceived hostile environment related to their sexuality, less education, lower income, and lower employment.[57] Native Americans, older men, and men who were bisexual or did not identify as any specific sexual orientation had the highest prevalence of suicide attempts. Attempts were also higher among men who reported adverse childhood experiences, such as parental substance abuse, repeated childhood physical abuse, and childhood sexual coercion. This study found that the age of disclosure of sexual orientation has been steadily declining over time, but that reported harassment has increased dramatically among younger generations.

Women with Perinatal Depression

According to the National Women's Health Information Center, a service of the U.S. Department of Health and Human Service's Office on Women's Health, perinatal depression occurs during pregnancy or within the first year after childbirth. Although the exact prevalence of perinatal depression is not known, it is believed to be one of the most common complications women experience during and after pregnancy. Since some of its symptoms are very similar to typical changes that occur around pregnancy and birth, perinatal depression may be under-recognized.

Although suicide rates among women who are pregnant or recently gave birth are lower than the general population of women, suicide is the second leading cause

of postpartum maternal deaths.[61] Up to 14 percent of women report suicidal ideation during pregnancy and the postpartum period.[61] Women who have a history of depression are at 70 times greater risk of suicide than those without this psychiatric history.[62] Throughout the first year after giving birth, over 30 percent of women who report postpartum depression continue to have depressive symptoms, and less than half improve within the first three months after giving birth.[63]

There may also be a link between maternal depression, recurrence of depression, and later behavioral problems in the child. Extended maternal depression can have a negative impact on attachment between mother and child, which may put the child at increased risk of developing behavioral problems.[64] Although perinatal depression was not specifically addressed in the Adverse Childhood Experiences Study, the study did find that children who grew up in a household where someone had a serious mental illness were more likely to attempt suicide at least once in their lifetime.[6] Therefore, it is important that pregnant women are screened for factors that may put them at higher risk for perinatal depression, including a history of depression and/or postpartum depression, throughout the year following birth in order to successfully recognize and treat maternal depression and also to reduce the likelihood of adverse impacts on the child.

The National Women's Health Information Center reports that postpartum psychosis is more rare than postpartum depression, occurring in approximately one or two out of every 1,000 births. It can include delusions, hallucinations, sleep disturbances, obsessive thoughts about the baby, and rapid mood swings. Postpartum psychosis typically begins within the first six weeks after childbirth. The risk of postpartum psychosis tends to be higher among women who have a serious mental illness, specifically bipolar disorder or schizoaffective disorder.

Means of Suicide

In a study of survivors of suicide attempts, almost half reported that less than one hour had passed between their decision to complete suicide and the actual attempt. Another 24 percent indicated it was less than five minutes.[65] The crisis leading up to suicide and suicide attempts is often short-lived, containing some impulsivity and ambivalence.[66] Restricting access to lethal means can put time between the impulse to complete suicide and the act itself, allowing opportunities for the impulse to subside or warning signs to be recognized and interventions to occur.

According to data from the CDPH, firearms are used in over 40 percent of suicides in California, followed by hanging (26 percent) and poisoning (19 percent). These three methods account for more than 85 percent of all suicide deaths. Almost half of males who died by suicide used a firearm, whereas the most common method used among females is poisoning (37 percent). Poisoning is the leading means of self-

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 166 of 220

inflicted, non-fatal injury, with alcohol and drug overdoses accounting for 77 percent of all poisoning incidents. The CDC defines a poison as any substance that is harmful to the body when eaten, breathed, injected, or absorbed through the skin. Poisoning occurs when too much of some substance has been taken, and generally the deaths that occur involve abuse of prescription or illegal drugs.

Addressing access to controlled substances and firearms is one way to prevent many suicides. The National Violent Death Reporting System (NVDRS) found that in 82 percent of firearm suicides among youth under 18, the firearm belonged to a family member, underscoring the importance of attention to safe storage of firearms in the home.[10] In many states, laws and practices do not uniformly ensure that information on persons restricted from possessing firearms is appropriately captured and available to the National Instant Criminal Background Check System.[67]

One explanation that has been suggested for the substantially higher rate of completed suicides among males is that females use means that may have a lower probability of lethality, such as poisoning. Among females, hanging or suffocation accounts for 71 percent of suicide deaths between 10 and 14 years of age, 49 percent of suicides between 15 and 19 years of age, and 34 percent between 20 and 24 years of age.[14] A review of over 600 coroner records in Riverside County, California, from the years 1998 to 2001, found that although women were over four times more likely to use poisoning than men, hanging was equally likely to be used by both sexes.[68] Furthermore, although women were 73 percent less likely to use firearms than men, firearms were the second most common means that women used.

The results of this study are supported by more current statewide data in California. Males and females are equally likely to use hanging as a method (26.5 percent and 26.2 percent respectively), and among females firearms are used in over 20 percent of suicide deaths.[9]

National data indicate that the use of lethal means, other than firearms, have increased, particularly among certain age and sex groups. Poisoning deaths accounted for 28 percent of the increase in the national suicide rate between 1999 and 2004.[h,69,70] In this same five-year period, the rate of suicide by hanging or suffocation increased, especially among adults ages 20 to 29 and 45 to 54.[70]

Given that the means to complete suicide by hanging or suffocation are usually more widely accessible and more difficult to control, prevention programs need to address access to lethal means in concert with education about suicide and psychosocial interventions that target groups at high risk.

Some research has suggested that individuals have a preference for a given means, and that if prevented from using it, an attempt may not occur.[66] The contagion effect,[e] personal ideas, and cultural factors all are likely to come into play when an individual is determining means.

NOTES

[e] The contagion effect is a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 167 of 220

The Cost of Suicide and Suicide Attempts

The emotional cost of suicide has both immediate and far-reaching effects on families and communities. It is estimated that each suicide seriously impacts at least six other people.[71] In addition to grieving the loss of the individual who took his or her own life, survivors – family members, caregivers, and friends – may themselves be at increased risk of suicide. The stigma associated with suicide may lead to reluctance to talk about the problem or to seek out social supports and mental health services.

> *"Each suicide seriously impacts at least six other people."*

Beyond the human suffering and emotional toll of suicide and self-inflicted injuries, there are also financial costs. The economic burden of suicide is spread throughout a variety of systems, including education, hospitals, primary care, mental health, and corrections. To estimate these costs, a formula has been derived based on costs incurred by individuals that attempted or died by suicide, families, employers, government programs, insurers, and taxpayers.[72] Estimates of the cost of self-injuries take into account hospitalizations and follow-up treatment; coroner and medical examiner costs; and transport, emergency department, and nursing home costs. Lifetime productivity estimates take into account lost wages, fringe benefits, and costs related to permanent or long-term disability for each individual who attempts or dies by suicide.

Using this formula based on suicide data from 1999 to 2003, the average medical cost per suicide in California was $4,781 and the average lifetime productivity loss for each individual was more than $1.2 million. The resulting cost of suicide deaths in a given year is nearly $15 million per year in medical costs and $3.8 billion in lost lifetime productivity for the individuals who die by suicide in a given year.

In 2003, there were over 16,000 hospitalizations for suicide attempts in California. The average medical cost per hospitalization was more than $12,000, and the average work-loss per case was over $14,000.[73] This amounts to $204 million in medical costs and over $230 million in lost productivity. The resulting cost of suicide attempts in a given year in California is $435 million.

Based on these figures, the combined estimated cost for suicides and suicide attempts in California is $4.2 billion per year.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 168 of 220

PART 2: STRATEGIES FOR SUICIDE PREVENTION

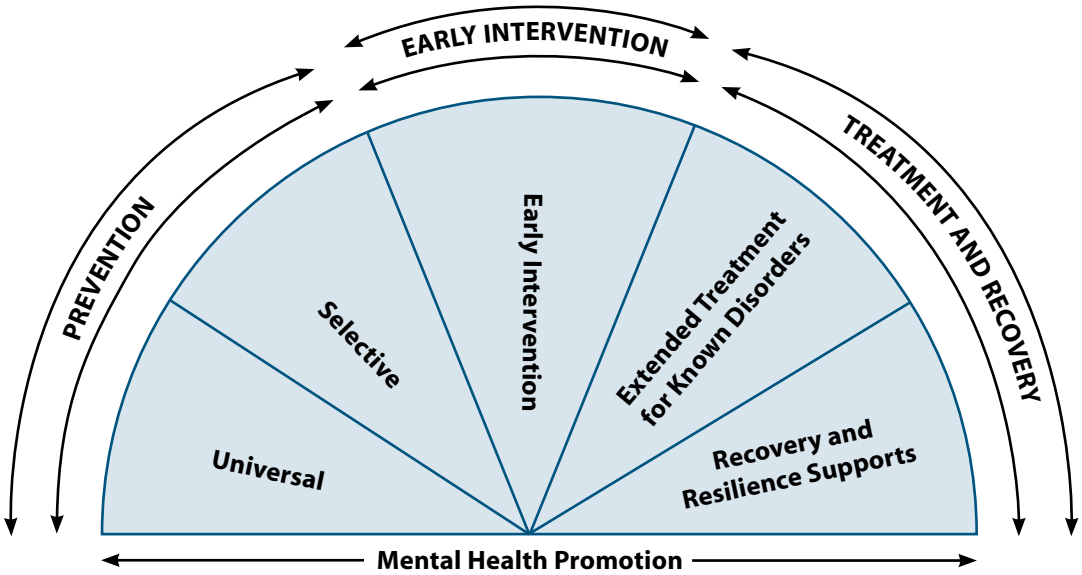
Suicide prevention encompasses a wide range of prevention, intervention, and postvention strategies that reduce suicidal behavior and its impact on family, friends, and communities. This spectrum includes mental health promotion strategies that offer education, foster resilience, and enhance protective factors in individuals and communities; build the capacity of providers and systems to offer appropriate services, including interventions to address mental health problems early and to reduce suicidal behaviors; and follow-up care services for those who have survived a suicide attempt and for family members and others who have suffered the loss of a loved one. Suicide prevention must also include research and surveillance to further understand demographic, cultural, social, and biological factors that reduce risk factors and promote help-seeking behavior. Evaluation is an essential element to ensure that programs are effective, as well as a program improvement tool. Recommendations for effective suicide prevention strategies have been reviewed in several key documents, such as the National Strategy for Suicide Prevention.[74,75,76]

Creating a System of Suicide Prevention

A system of suicide prevention would include a range of gender-specific services and programs designed to effectively meet the needs of individuals of all ages and from diverse racial, ethnic, cultural, and linguistic backgrounds. The success of the system will be judged not solely on the value of any one component or service but rather how well the parts are coordinated and build upon one another. Linkages are critical because it can be anticipated that increased community outreach and education efforts to promote mental health, build resilience, and increase awareness of the

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 169 of 220

Figure 3: Mental Health Intervention Spectrum Diagram.



Source: Adapted from Mrazek and Haggerty (1994)[145] *and Commonwealth of Australia (2000)*[146]

suicide warning signs may result in increased service demands further along the Mental Health Intervention Spectrum (e.g., screening and assessment to early intervention and crisis services; see Figure 3). Fragmentation of systems presents a fundamental challenge to continuity of care that can cost lives.[77]

To ensure that the system for suicide prevention is effective, it is critical to assess the assets and gaps, make a plan, implement, and reassess. To create such a system, coordination and partnerships must occur at multiple levels. Collaborative models need to be developed to ensure that professionals from different disciplines and service systems that have important roles in preventing, assessing, and treating suicidal behavior can communicate with one another and coordinate their activities.

Coordination at the State Level

To achieve maximum benefit and efficiency throughout our large state, it is imperative that a centralized, coordinating body for the various suicide prevention activities is charged to effectively reach and serve the diverse populations of California.

This strategy has been effective in other states. Maryland implemented a model state prevention and awareness program and now has the fifth lowest suicide rate in the nation.[78] Coordinating programs at the state level has resulted in increased federal funding for suicide prevention activities and successful coordination of training for gatekeepers throughout the state. Other states, such as Colorado, Florida, and Nevada, have established an office to coordinate suicide prevention activities statewide.

On February 6, 2008, the California Department of Mental Health, in collaboration with Assembly Member Mary Hayashi, announced the establishment of an Office of Suicide Prevention (OSP). OSP will provide

a single point of contact and a central point of dissemination for information, resources, and data about suicide and suicide prevention programs. It will serve as a liaison with national partners, such as the Suicide Prevention Resource Center and the Substance Abuse and Mental Health Services Administration, as well as other states. The office will ensure that activities build upon resources and materials where they already exist, and it will provide expert consultation on local suicide prevention plans and activities.

The California Office of Suicide Prevention will support integration of resources and activities for suicide prevention through various state and county systems and organizations. It will centralize coordination of strategic suicide prevention, intervention, postvention, and research activities throughout the state, including dissemination of model training curricula and service guidelines targeted to different professional groups and settings. It will provide leadership in developing learning communities among the diverse partners throughout California and among stakeholders within the counties, through disseminating and coordinating resources for community planning, leadership training, and building program capacity. Additionally, the Office of Suicide Prevention would be a partner in the development of social marketing efforts focused on increasing community awareness and education, addressing stigma, and reducing suicidal behaviors.

> *"The California Office of Suicide Prevention will support integration of resources and activities throughout state and local systems."*

Finally, the office will oversee the development of a research agenda to fill gaps in knowledge about suicide and suicidal behavior of Californians from diverse backgrounds, and it will aid in the evaluation of interventions to ensure they are effective. It will also coordinate periodic review and update of this *Strategic Plan on Suicide Prevention*, including tracking selected indices of suicidal behavior over time.

Coordination at the Local Level

Many of the partners in a local system of suicide prevention are entities with county, municipality, or district-wide jurisdictions. Local coordination efforts need to include assessment, planning, implementation, and evaluation of the wide range of suicide prevention efforts needed at the community level.

Universal (community-wide) and targeted social marketing strategies are a critical component of the prevention efforts. Campaign activities should be designed to outreach to populations at risk, educate the general public on warning signs and resources, and engage with local media outlets on appropriate reporting guidelines. The messages and materials used should be culturally and linguistically appropriate as well as specific to the age and gender of the target population. Greater success may be achieved by coordinating public education efforts with supportive programs and policies.

Many effective practices integrate suicide prevention into existing community settings and services and utilize key points of contact or "gatekeepers," such as community health

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 171 of 220

workers or promotoras, school staff, primary care providers and staff, and Area Agency on Aging personnel and volunteers.[1,79] These strategies are particularly effective for groups that are underserved by the traditional mental health system and are more likely to be identified by or seek help through other community supports. Some strategies offering a more effective response to suicide prevention and suicide include co-location of mental health services and primary care services, integrating mental health services into school-based clinics and aging services, and cross-discipline suicide assessment and intervention training. Working with youth development programs at schools, recreation centers, churches, and other locations also serve as possible venues for teaching problem-solving skills, conflict resolution, and building resiliency; all of which play a role in suicide prevention.

To effectively prevent suicide, it is critical that each county have well-coordinated crisis response services. These services should be able to respond to acute crisis situations involving emergency department and hospital staff, mental health providers, and law enforcement personnel. Crisis response services should also include hotlines and mobile outreach teams so that help is readily available when and where needed. Easily accessible and up-to-date directories of local suicide prevention and intervention resources would benefit individuals at risk, the general public, and providers in different systems.

"Peer support models can play an essential role as part of a coordinated system."

Safety plans for facilities, such as school campuses, increase preparedness to effectively respond to a crisis, including suicide attempts.

Hospital emergency departments often treat individuals with self-inflicted injuries. However, discharge planning procedures for emergency departments vary in their provision of referrals for professional mental health assessments and follow-up services.[80] There needs to be consistency across hospital, emergency department, and other inpatient settings to implement protocols for follow-up care and effective referral to ensure the continuity of care that can save lives.

Peer support models can play an essential role as part of a coordinated system by improving quality of life, fostering recovery and resiliency, and preventing a crisis from developing. Support services provided by those who have experienced suicidal feelings, thoughts, and attempts, and who have survived and rebuilt their lives, can play a vital role in preventing suicide and in preventing the trauma that often accompanies the need for acute, emergency interventions. Peer support programs typically offer short-term, residential crisis services administered by peers; warm lines[f]; programs to promote health, wellness, and recovery; and forums to educate the public about mental illness and mental health.

The factors surrounding a suicide death are often complex, and the stigma of suicide may influence the accuracy of reporting, which can impact the ability to identify systemic changes

NOTES

[f] Warm lines are phone lines staffed by peers that provide support and education. Warm lines are generally intended to help prevent a situation from developing into a crisis.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 172 of 220

that may be necessary to prevent future deaths.[81] A review of the local data and findings would be helpful to determine where additional attention to existing policies, services, or practices needs to be focused.

Enhancing Mental Health Early Intervention and Treatment

Intervention activities should target periods of time when research and surveillance data have indicated that suicide risk is high, such as initial onset of a mental illness and immediately after a hospital discharge.[29,82] However, one of the most promising ways to prevent suicide and suicidal behavior is through recognition of early signs of mental health problems stemming from depression, loneliness, and other needs.[7] Psychosocial therapy that strengthens problem-solving skills can help to address the feelings of hopelessness and of being overwhelmed and unable to change negative situations that lead to increased risk of suicide.[4] Due to the strong link between severity or recurrence of episodes of serious mental illness and risk of suicide, consistent and appropriate treatment is crucial to suicide prevention.[27] In addition to risk factors among the general population, individuals diagnosed with a serious mental illness have other specific risk factors, such as severity of symptoms and numerous relapses.[29]

> *"Surveys of individuals who have used hotlines indicate that levels of emotional distress and thoughts of suicide are decreased by the calls."*

Many mental illnesses are associated with an elevated risk of suicide, therefore identifying and treating mental illness early in its onset is an important prevention strategy. There is some evidence for the value of routine screening in certain primary care settings to identify early signs and symptoms of mental illness.[83] The U.S. Preventive Services Task Force, an independent panel of experts that develops recommendations for clinical practice, recommends the use of screening tools for depression in adults in primary care settings.[84] However, the Task Force found that the evidence for the effectiveness of screening for suicide risk in primary care settings is limited.[85]

Screening for depression during routine postnatal primary care visits is associated with a three-fold increase in detection of postpartum depression among women.[86] Multiple depression screening tools have been developed that are targeted for the primary care setting. The "PHQ-9 Two-Question Screen" includes a nine-symptom checklist that the primary care professional uses to assess potential mental health problems, including depression. Another example is the "four Quadrant Model" based on a similar model that the National Council for Community Behavioral Healthcare developed in 1998. This model separates individuals undergoing screening into four quadrants or categories of behavioral health and physical health, depending on the severity of their needs in each area. The model addresses a broad spectrum of health and mental health issues and co-occurring disorders, including various stages of depression.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 173 of 220

With enhanced screening efforts comes the responsibility to ensure that prevention programs and community services and supports that are culturally and linguistically competent, participant-driven, recovery-based, and trauma-informed are available to people who need them. A focus group study administered by the California Network of Mental Health Clients found that where there is a lack of voluntary, community-based mental health services and supports, many mental health clients who seek services fear that overly restrictive modes of treatment will be the only services available in a suicide crisis.

Sharing Information between Systems

Recent events have highlighted the issue of confidentiality laws and information sharing related to mental health. The *Report to the President on Issues Raised by the Virginia Tech Tragedy* found that there is variability in understanding confidentiality laws that can result in confusion and barriers between legitimate information sharing among service providers and systems.[67]

Confidentiality laws can be complex and often differ from state to state. States that allow for disclosure of mental health information usually limit it to diagnosis, prognosis, and information regarding treatment, generally medication.[87] Additionally, providers, clients, family members, and others disagree about when disclosure is appropriate. Confidentiality issues are of particular concern for the mental health system because of the ongoing problems of stigma and discrimination associated with mental illness. Until this larger problem is addressed, confidentiality issues will continue to be a significant challenge for strategies that seek to integrate systems and services.

Targeted Approaches

Several suicide prevention strategies enhance targeted crisis intervention services for individuals who may be contemplating suicide, or target specific population groups who may be at high risk of suicide. Targeted approaches are an important component of a system of suicide prevention that is responsive to diverse needs within communities.

Suicide Prevention Hotlines

Suicide prevention hotlines are an effective way for people in crisis to reach out for help, and those who use the lines report that they are helped by the calls. Surveys of individuals who have used hotlines indicate that reported levels of emotional distress and suicidal ideation are decreased by the end of the calls.[88,89] However, hotlines that are not accredited may differ in whether suicide risk assessment procedures are completed and in thoroughness of the assessment, which can result in uneven quality of response across locations.[88] Although the DMH requires each county's Mental Health Plan to operate a 24-hour, toll-free telephone line that provides information about accessing services and problem resolution processes, these lines may not include suicide prevention assessment and intervention.

The National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour, toll-free hotline funded by SAMHSA. The National Lifeline consists of over 125 accredited call centers in 45 states around the country. When a caller accesses the Lifeline, the call is immediately routed to the closest affiliated call center. Callers can remain anonymous, minimizing concerns about stigma that may inhibit people in need from seeking mental health services elsewhere. To address the needs of callers who do not speak English as their primary language, the Lifeline operates

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 174 of 220

a network of nine Spanish-language call centers across the nation, two of which are in California, and all Lifeline call centers have free access to a live language interpretation service that includes over 170 languages.

To become a member of the Lifeline, call centers must be accredited by an organization, such as the American Association of Suicidology, or licensed or certified by their county or state. This process ensures that responders are trained in evidence-based risk assessment procedures and that these procedures are consistently administered to all callers. The accreditation standards that the Lifeline accepts were developed with the involvement of national and international experts in suicide prevention to ensure incorporation of the latest research and information.[90] Call centers applying for accreditation for the first time may receive technical support from the organization that will review their application. Once accredited, call centers can apply for National Lifeline membership that includes a modest annual stipend, coverage of the phone line costs to calls placed to the Lifeline number, and ongoing technical assistance to ensure continuing, uniform quality across the network.

"In 2007, approximately 20 percent of calls that originated in California were answered by suicide prevention hotlines in other states."

Currently, eight hotlines in California are members of the National Lifeline. Although anyone in California can call the Lifeline number, depending on their location, they may not reach a call center in their area or even in the state.

Data from the National Lifeline indicate that in 2007, approximately 20 percent of calls originating in California were answered by hotlines in other states. California-generated calls that come from counties that do not have a Lifeline-accredited call center are routed to accredited call centers in other counties based on their availability and capacity (e.g., staff availability, busy lines, billing limitations). In a typical day, in addition to handling all the local calls in the Los Angeles area, the Didi Hirsch Community Mental Health Center takes calls from Santa Cruz, Fresno, Shasta, Sacramento, San Mateo, Kern, and Napa counties. When the Didi Hirsch Center cannot answer a call, such as when all its lines are busy, these California callers are served by a call center in Nebraska.

If calls are not answered locally, responders may not be able to refer individuals in crisis to local resources for follow-up care. California needs to increase the capacity of suicide prevention hotlines so that callers from every county can access a local, accredited call center. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple-language capacity, of suicide prevention hotlines.

Hotlines have also been used to target prevention activities for specific populations. The San Francisco Institute on Aging Center

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 175 of 220

for Elderly Suicide Prevention operates the Friendship Line. The line offers phone-based services, such as 24-hour crisis intervention and elder abuse prevention, as well as grief counseling, well-being checks, and information and referral services.

Several hotlines target youth. For example, the Trevor Project is a national crisis and suicide prevention hotline that focuses on lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. This service is provided 24 hours per day, seven days per week and is free and confidential. The Trevor Project also hosts a website with education resources such as training models and teaching guides, and an online forum that serves as a virtual warm line.

Finally, the VA and SAMHSA have collaborated to provide suicide prevention hotline services that are targeted to veterans. Individuals may now call the National Lifeline and choose a prompt to identify their veteran status. They are immediately transferred to a hotline staffed by mental health professionals at a VA facility in upstate New York, who will have information about VA resources throughout the nation.

Population-Specific Interventions

Due to the unique characteristics of different age groups and ethnic populations and their disparities in access to services, effective approaches to suicide prevention need to include outreach and intervention strategies that specifically target these specific groups.[91,92]

Older Adults

Depression is a significant risk factor for suicide in older adults, and it is also a condition that may go unrecognized and thereby remain untreated.[93] Frequently, signs of mental health problems are missed because they are mistaken as a normal part of aging, or they are misdiagnosed as cognitive impairments that are increasingly common with advanced age.[11,94,95] Finally, where mental health problems are recognized, the stigma associated with mental illness may influence the likelihood of seeking mental health treatment.[95]

> *"The majority of older adults who died by suicide visited their physician within one month of their death."*

Although the majority of older adults visited their primary care physician within a month of their suicide, most of them were not receiving mental health treatment. Traditional mental health service systems are often not the most effective way to reach and serve older adults who may be at risk, and primary care services need to be improved.

Multiple evidence-based programs have been developed that target older adult mental health. Currently, ten programs are listed on the SAMHSA National Registry for Evidence-Based Programs and Practices (NREPP).[96] Most of these programs contain components for outreach, engagement, and education that are embedded within existing community structures and services that older adults commonly use.

Other effective approaches integrate mental health services into primary care, such as co-locating health and mental health services. The Prevention of Suicide in Primary

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 176 of 220

Care Elderly Collaborative Trial (PROSPECT) combines treatment guidelines for depression in primary care settings with comprehensive care management for older adults diagnosed with depression.[96] Trained clinicians work closely with the primary care provider, the older adult patient, and their family around treatment protocols and education. One outcome of this program was a statistically significant reduction in suicidal ideation among participants.[97]

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment) is an intervention for patients 60 years or older who have major depression or dysthymic disorder.[96] The intervention is a collaborative care approach in which a nurse, social worker, or psychologist works with the primary care provider, a depression care manager, and the patient to develop a multi-modal course of treatment that includes medications, exercise, identifying positive activities to engage in, and education about late life depression. IMPACT has been evaluated with racially, ethnically, and linguistically diverse older adults, including Whites, Latinos, and African Americans. Outcomes of this intervention include significant reductions in depression and improvements with work, family, and other social relationships. The IMPACT model has also been shown to be more cost effective than usual medical-based care for depression in older adults.[11]

There is also a need to address Medicare and insurance reimbursement issues that may create barriers to mental health services for older adults.[94,98] The Program of All Inclusive Care for the Elderly (PACE) provides a model for coordinating Medicaid and Medicare financing with community-based social, mental health, and primary health services to provide an alternative to nursing home care.[96] An interdisciplinary treatment team oversees the implementation of the individualized treatment plan for each older adult enrolled in the program. Results from this program include decreased use of acute services, improved health and quality of life, and lower mortality rates.

Survivors of Suicide Attempts and Suicide Loss

Engaging those who have been directly impacted by the tragedy of suicide can be a powerful tool to prevent suicide and future attempts and to support those who have lost a friend, colleague, or loved one to suicide. A growing body of literature substantiates the effectiveness of services and supports offered by individuals directly impacted by mental illness, such as warm lines and peer-run support centers.[99] Organizations like the California Network of Mental Health Clients and the National Alliance on Mental Illness are important sources of support, advocacy, and education for mental health clients and their family members.

In response to the high rate of suicide in Humboldt County, the California Network of Mental Health Clients recently organized Suicide Alternatives Workshops that bring together survivors of suicide attempts, family and friends of those who have died of suicide, clergy, mental health clients, mental health professionals, and physicians. The workshops are held monthly and provide ongoing community education, outreach and peer support, and recommendations for local policy and practice.

Another promising practice is web-based self-help, which is a cost effective approach to providing information and resources to those who have access to the Internet. Examples include the National Empowerment Center

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 177 of 220

(www.power2u.org), a national consumer technical assistance center. Another example is "Beyond Blue," the national depression intervention initiative in Australia that hosts a website that offers self-assessment tools and resources to find mental health care, post notices on a bulletin board, and learn more about research (www.beyondblue.org).

Several programs, many of which are school-based, have been developed that facilitate peer support among high-risk youth. The Trevor Project hosts an online peer support venue for lesbian, gay, bisexual, transgender, and questioning youth. Models for implementing a range of youth peer support programs are available on the website for SAMHSA's National Registry for Evidence-based Programs and Practices.[96]

> *"Many evidence-based practices have not been tested among diverse populations."*

Racial, Ethnic, and Cultural Communities

The U.S. Surgeon General has reported significant disparities in access, availability, and quality of mental health treatment services for racial and ethnic populations as compared to Whites.[100] These disparities are evident in the paucity of culturally and linguistically appropriate mental health services and supports, including inconsistency in language access in services, hotlines, and informational materials, and in the fact that many evidence-based practices have not been tested among diverse population groups.

Cultural differences matter substantially. African Americans are more likely to be incorrectly diagnosed than Whites and are also more likely to leave psychiatric treatment earlier.[100] This situation may be due in part to the possibility that African Americans may present their symptoms and respond to treatment differently from what most clinicians are trained to expect.[100] Furthermore, African Americans are substantially less likely than Whites to have access to treatment providers who are of the same race.[100] Fears of racism may exacerbate the problems of stigma and discrimination around mental illness.

Other cultural factors may adversely impact the mental health and suicide risk of immigrants and refugees, such as intergenerational conflicts related to acculturation, family pressures around academic achievement, and adverse experiences from the home country, including war, torture, and genocide.

California is a diverse state. Data from the 2000 Census indicated that the majority (53.3 percent) of California's population identified as non-White, and 40 percent spoke a language other than English at home.[101,102] A quarter of the population was born outside of the U.S., and the majority of Asians and almost half of Latinos are foreign born.[103] A combined 63 percent of these populations are concentrated in the San Francisco Bay Area and Los Angeles. To address the needs of this diverse population, mental health and suicide prevention services

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 178 of 220

need to identify and develop culturally appropriate outreach and engagement activities and diagnosis and treatment strategies.

Promising strategies include engaging diverse communities through natural community leaders and helpers, such as faith leaders, community health workers (e.g., promotoras), or indigenous healers. If trained to recognize and respond to warning signs of mental illness and suicide risk, these individuals are in a position to promote early intervention for individuals at risk who may not otherwise seek professional help. A process of community engagement to determine the strategies used and to evaluate their effectiveness, for example, through community participatory action research methods, can increase the validity, acceptability, and sustainability of culturally appropriate mental health and suicide prevention practices within diverse communities.[91] Interventions need to be specific, targeted, and culturally relevant, including the role of families, faith communities, traditions, and other values and attitudes that address perspectives on suicide and mental illness.

To address disproportionately high suicide rates in Native American communities, particularly among youth, effective approaches must be developed through an inclusive process. Although few evidence-based practices have been tested in Native American communities, tribes are actively engaged in developing and adapting best practices.[104,105]

For example, the Jicarilla Apache of Northern New Mexico developed a community intervention program involving tribal leadership, community members, youth, clinicians, university researchers, and the Indian Health Service that resulted in a 60 percent decline in suicides over a ten-year period.[106] Additionally, tribal programs in Phoenix and Alaska have implemented successful suicide prevention strategies that include training that incorporates not only suicide prevention and intervention, but also culturally-specific, traditional approaches and perspectives.[106]

The Zuni Life Skills Development program is a school-based curriculum designed to reduce suicide risk and enhance protective factors among Native American adolescents.[96] The curriculum includes topics such as building self-esteem, decreasing stress, increasing communication and problem-solving skills, and recognizing and eliminating self-destructive behaviors. Lessons are taught by a team of teachers and community resource leaders to ensure a high degree of cultural and linguistic relevance. The Zuni Life Skills Development curriculum served as the basis for the broader Life Skills Development curriculum that is now in use with other Native American populations.

It is also important that mental health and health providers reflect the diversity of the population they are charged with serving, including language diversity, so that people of all cultures, ethnicities, and languages can feel comfortable seeking services that they are confident will appropriately and effectively address their needs. More research is needed about effective models and to test existing practices for their effectiveness among diverse populations.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 179 of 220

Children, Youth, and Young Adults

It is important to promote protective factors against suicidal behavior in young people. A review of interventions by the Centers for Disease Control's (CDC) Task Force on Community Preventive Services reported that early childhood home visitation programs can prevent adverse outcomes, such as child abuse and neglect.[107] Furthermore, therapeutic foster care reduces violence among chronically delinquent juveniles. This is an important outcome, since 25 percent of serious violent offenses in the U.S. are committed by youth between the ages of 10 and 17 years. This task force did not evaluate the impact of these programs on suicide. However, the approaches promote protective factors and mitigate risk factors that can also lead to an increased risk of suicide in this vulnerable population.

Because school is where many youth spend a large part of their days, school staff are in the position to detect the early stages of mental health problems and potential suicide risk. By 2000, 77 percent of schools in the United States had implemented a suicide prevention program.[79] Some programs use early intervention strategies, such as screening instruments that detect warning signs of self-harm and suicidality. Mental health and suicide prevention programs that are school-based can be successful in encouraging students at risk to seek help, and to follow through on referrals to mental health services. The programs can also be successful in developing protocols to handle a suicide crisis that minimizes the chances of a contagion effect.

School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, conflict resolution, and nonviolent handling of disputes. One study found that a universal[9] intervention program (the Good Behavior Game) that focused on socializing first and second grade students toward reducing aggressive, disruptive behavior was associated with significant decreases in later onset of suicidal ideation and attempts.[108]

This approach may be particularly important for adolescents and youth who are coping with the stigma and prejudice associated with exploration of sexual orientation and gender identity. One study found that heterosexual students reported higher levels of protective factors, such as family connectedness, adult caring and involvement, and feeling that the school was a safe place, than homosexual students.[109]

Unfortunately, many young people who are at high risk of suicide may have already stopped attending school or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals through community groups and places where young people congregate. It is also important to train the program staff who provide services to at-risk youth to ensure they are able to recognize the warning signs of suicide and how to intervene early.

Nationally, many more children and youth need specialized mental health services than actually have access to them.[83] Several strategies have been recommended to improve service delivery and training of providers, particularly in primary care, who routinely come into contact with adolescents

NOTES

[9] Universal refers to an intervention that addresses an entire population, in this case, all first and second grade children enrolled in the schools were involved in this study, not solely those identified as at higher risk.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 180 of 220

and youth who may be at heightened risk of emotional disorders or suicidal behavior. Examples are co-location and training of child mental health specialists to work in primary care settings, and enhanced training in medical school and for providers in practice.[83]

> *"Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it."*

The tragic events at Virginia Tech raised national awareness of the need for earlier and better comprehensive mental health services on college campuses. Some of the key findings of the *Report to the President on Issues Raised by the Virginia Tech Tragedy* (2007)[67] are included as follows:

- Sharing critical information among education officials, health care providers, law enforcement personnel, and others can address obstacles resulting from confusion about confidentiality laws.
- Parents, students, and teachers need to learn to recognize warning signs and encourage those who need help to seek it.
- There must be effective coordination of providers who are sensitive to the issues of safety, privacy, and provision of care to ensure that people with mental illness are integrated into the community.
- Full implementation of emergency preparedness and violence prevention plans is needed to address problems of school and community violence.

SAMHSA has launched a suicide prevention initiative that targets adolescents and youth. The Campus Suicide Prevention Grant Program provides funds to assist colleges and universities in their efforts to prevent suicide attempts and completions and to enhance services for students with mental health problems, such as depression and substance abuse that put them at risk for suicide and suicide attempts. Program requirements include providing suicide prevention training and education programs for students and campus personnel, enhancing the network of campus mental health services to include the broader community where needed, developing campus-based hotlines or linking hotlines with the National Lifeline, and disseminating materials to the campus community, as well as families, to educate them about the warning signs of suicide and to counter stigma and encourage help-seeking behaviors.

In addition, the State/Tribal Youth Suicide Prevention Grant Program provides funds to states or tribes to develop a public/private coalition among youth-serving institutions and agencies, including schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth-supporting organizations. This coalition is responsible for implementing a youth suicide prevention plan that includes enhanced assessment, early intervention, and treatment for at-risk youth.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 181 of 220

Increasing the availability of mental health and suicide prevention services on college campuses is an important step in preventing suicide among young adults. Reports from the California Department of Education and the University of California, among others, have recommended implementation of strategies to achieve this step.[15,110] However, a suicide prevention system for young people must include strategies that start much earlier than the presentation of suicidal ideation or acute mental health problems.

> *"A system of suicide prevention must include strategies that start well before the presence of suicidal ideation and acute mental health crises."*

Correctional Facilities and Law Enforcement

Many effective programs offer models for partnership between the criminal justice and mental health systems, for example, jail diversion and re-entry programs. By building local partnerships between and within the criminal justice system and at the community level, suicide risk among inmates can be reduced along with the medical cost of treating acute problems, which will provide a safer setting for inmates as well as staff.[111]

To address the mental health needs and suicide risk of individuals who, being released from jail, were repeat offenders, or were being discharged from an inpatient psychiatric facility, one community in Monroe County, New York, developed a coalition of community care providers, the county mental health department, local criminal justice systems, the courts, and the university psychiatry department to coordinated outreach and services.[112] Over 100 individuals received services through the program. Outcomes of this project included no suicide attempts, assaults, or other reportable incidents during the study period among subjects, and the reduction in jail and hospital expenses amounted to approximately three times the program's cost. The findings from research and data on the needs of this population provide strong support for implementing programs in jails and prisons as well as programs that support re-entry into the community.

According to the California Department of Corrections and Rehabilitation, California's prison system paroles over 100,000 inmates every year.[113] Many of these inmates will require community services to maintain their health, mental health, and well-being after release. Recently, the California Legislature has required the Department of Corrections and Rehabilitation and community agencies to work together to provide better re-entry programs and services for parolees. Collaboration between the prison system, community social services, and the community mental health system is necessary to support this effort to provide continuity of care,

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 182 of 220

particularly as California's prison system continues to shift toward a recovery and rehabilitation model for inmates with severe mental illnesses.

Employers

Integrating suicide prevention into work settings is recommended to reach a large number of adults who may be at risk, but who are not currently utilizing or likely to seek out mental health services. Resources need to be developed and disseminated to employers that provide guidance about how to recognize and assist employees who may be exhibiting warning signs of suicidal behaviors, who are coping with family members or friends of individuals presenting with suicidal behaviors, or who are themselves survivors of suicide. Recently, the Partnership for Workplace Mental Health, which includes the American Psychiatric Association, the American Psychiatric Foundation, and business leaders, launched *Employer Innovations Online* (www.workplacementalhealth.org). This searchable online database provides resources, models, assessment tools, and detailed information for employers to develop strategies to address workplace mental health issues.[114] Another resource is the National Business Group on Health, an organization that provides information and resources on health and mental health issues in the workplace.[115]

Employers should be encouraged to access these resources as well as to build and maintain a directory of local prevention, treatment, and support services and make them readily available, in a non-stigmatizing manner, to all employees. Another approach is to build outreach and education about suicide prevention and mental health into existing support networks, such as employee assistance programs, to reach people who might not otherwise seek help.

Veterans and the Military

Given the magnitude of the problem of suicide among veterans, it is critical that the military and the reserves are partners in implementing the *California Strategic Plan for Suicide Prevention*, including the California National Guard and the VA medical centers in the state. Strategies to address suicide prevention among veterans must take into account the prevalence and characteristics of stigma and fears of discrimination in the military that constitute barriers to needed care. Strategies must also address access to mental health services, especially for veterans who may live far away from a VA Health Center. The increasing volume of need for mental health services among the thousands of veterans returning from Iraq and Afghanistan must also be met.

Beginning in fall 2003, the Army convened Mental Health Advisory Teams to annually review data on mental illness and suicide among deployed soldiers, assess quality and access to mental health care, and provide recommendations for improvements.[116] Recommendations from early MHAT reports led to the Army Suicide Event Report, a reporting and tracking mechanism that collects extensive data about suicides and attempts. The development of the VA Suicide Prevention Lifeline is another step toward addressing veterans' specific and urgent mental health needs.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 183 of 220

Multi-Level Public Health Approach

The Air Force Suicide Prevention Program is an evidence-based practice that was developed in response to a rise in the suicide rates in the Air Force in the early 1990s.[117] The program uses a multi-level intervention targeted at reducing risk factors and enhancing protective factors, including reducing stigma around seeking help, promoting education about mental health, changing policies, and shifting social norms. Eleven initiatives were implemented, including the following:

- Strong messaging from the Air Force Chief of Staff that promotes social support between officers, supervisors, and coworkers and the value of seeking mental health services early.
- Requiring personnel to receive suicide prevention training, and encouraging each Air Force installation to tailor training programs to the needs of the local community.
- Improving surveillance through an online database and developing a survey that provides specific feedback to help tailor interventions to each community.
- Developing local crisis and critical incident response management teams.
- Coordinating and integrating services among faith-based programs, mental health services, family support centers, child and youth programs, family advocacy programs, and health and wellness centers.

The program resulted in significant increases in Air Force personnel that were trained in suicide prevention and educated about violence prevention.[118] After implementation of the program, there were significant reductions in suicides, homicides, accidental deaths, and moderate and severe family violence. The success of this model indicates that systemic interventions that change social norms about seeking help from being a sign of weakness to a sign of strength, and institutionalization of training about suicide prevention can have substantial impact on promoting mental health and reducing a range of adverse outcomes.

The universal, multi-layered strategy exemplified by the Air Force Suicide Prevention Program is a good example of an approach that has been used to successfully address other public health problems, such as reducing cardiovascular disease.[119] Efforts to address the broader, modifiable risk factors that predispose individuals to heart disease were developed in parallel with technological advances that improved outcomes for people who have already developed the disease. Along with activities such as education about recognizing the warning signs of a heart attack, widespread training in cardiopulmonary resuscitation, and the development of new medicines and technologies were strategies that educated the public about the benefits of a healthy lifestyle and of reducing or eliminating behaviors that contribute to long term risk. Changes in public policy, such as laws related to smoking, supported this shift in cultural and social norms that has reduced the risk of a range of diseases.

There is a difference between the traditional, clinical-based approach to suicide prevention and the public health approach that was

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 184 of 220

employed by the Air Force Suicide Prevention program. The clinical approach rests on identifying and treating individual risk factors when evidence of disease is present. Typical suicide prevention strategies have focused largely on recognizing warning signs and individual-level risk factors rather than considering the important role of population-level mental health promotion with all individuals on a continuum of risk. Interventions are broad, multi-layered, and occur both well before a problem arises as well as at various phases after it is present. The Air Force Suicide Prevention program demonstrates that when a public health approach is applied to the problem of suicide and a broad range of prevention and early intervention strategies are put into place, the likelihood of multiple negative outcomes, including suicide, mental illness, and violence, are all reduced.[118,119]

Implementing Training and Workforce Enhancements

Effective suicide prevention strategies depend on a trained workforce and an educated public. It is imperative to ensure that providers in multiple service fields are equipped to recognize and intervene when suicide risk is present. Training and service guidelines need to be implemented, targeting the specific concerns and opportunities for intervention that are present in different settings, including primary care, mental health clinics, classrooms, juvenile justice facilities, substance abuse treatment programs, older adult and long term care programs, and the venues served by law enforcement and probation officers.

Establishing Guidelines for Professionals

A substantial precedent exists for establishing guidelines for training and service in selected occupations. For example, the American Psychiatric Association has developed guidelines for mental health professionals, and the SPRC has developed a curriculum for suicide prevention programs within law enforcement departments.

SAMHSA and the SPRC have developed materials that support the development of guidelines in campus settings. For example, *Promoting Mental Health and Preventing Suicide in College and University Settings* provides recommendations for institutions of higher education to assist with the implementation of suicide prevention programs.[120]

Finally, tools for assessment of suicide risk in emergency departments have been developed, as well as guidelines for emergency department providers around care and discharge planning for individuals who survived a suicide attempt.[82,121] Currently, SAMHSA, the SPRC, and the National Suicide Prevention Lifeline are working with the American Academy for Emergency Psychiatrists and the Emergency Nurses Association to raise awareness for providers and develop and disseminate training for emergency medical providers.[h]

Health, Mental Health, and Social Services

Health clinics, i.e., primary care and prenatal care, mental health centers, emergency response systems, crisis centers, and alcohol and drug programs, are key access points. Personnel in these systems need to have consistent guidelines for effective assessment and treatment interventions.

Unfortunately, there are many missed opportunities for prevention and early intervention among people who are at risk

NOTES

[h] For more information, visit the websites for SAMHSA (www.mentalhealth.samhsa.gov), SPRC (www.sprc.org), and the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org/).

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 185 of 220

of suicide. Improved training guidelines and service protocols will better prepare providers to appropriately respond when suicide risk is present. Equally critical is the need to appropriately assess for mental health conditions that are associated with significant increase in suicide risk, such as depression. Although routine screening has been shown to be effective in identifying and successfully treating depression among adults and older adults, it is important that screening be accompanied by policies ensuring confidentiality and protection from discrimination, along with the availability and accessibility of appropriate, quality, follow-up services.

> *"Mental health professionals in California do not have a licensing requirement specifically focusing on suicide risk assessment and treatment."*

In one study of physician visits by patients presenting with either major depression or an adjustment disorder, physicians asked questions about suicide in only 36 percent of visits.[122] Physicians were more likely to ask questions about suicide if they had personal experience with depression or if the patient prompted the discussion. Health providers may be reluctant to ask questions about suicide risk if they do not feel adequately trained in suicide assessment and treatment, or if they do not know how to refer patients to a mental health provider who can provide these services. Educating health professionals to recognize and treat depression and other conditions that present a heightened risk of suicide and providing them with the tools to consistently and properly address suicide can prevent suicide deaths.[122,123]

A survey of over 300 emergency departments in California found that most rely on external mental health professionals, such as mobile crisis, private psychiatric evaluation teams, or social workers to provide suicide assessments and referrals.[80] Yet mental health professionals in California do not have a standard competency or licensing requirement that specifically focuses on assessing, treating, and caring for patients at risk for suicide. The majority of respondents identified a need for increased access to mental health professionals to be able to adequately help individuals who enter emergency departments in mental health or suicide crises.

Older adults have the highest rate of suicide, and depression is a significant risk factor for suicide among older adults. It is critical that medical professionals who treat older adults and staff working in older adult services, long-term care, and adult protective services programs, should be trained to recognize warning signs and risk factors of depression and suicide in older adults.

Staff working in social services, child protection, foster care, and juvenile justice interact daily with high-risk youth and are in a critical position to identify and intervene when adverse childhood experiences have taken place or suicidal ideation and behavior are present. To appropriately identify and reduce suicidal behavior, staff in these systems need to be trained in age-appropriate prevention and early intervention strategies that are effective for the populations they serve.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 186 of 220

Law Enforcement

Law enforcement officers are often the first on the scene when a suicide crisis emerges. They also come into contact with family members and other loved ones of individuals who have died by suicide. Several evidence-based training models exist that educate officers about the signs of mental health problems and suicide risk and how to appropriately intervene while maintaining public safety.[32] For example, the Crisis Intervention Team (CIT) program provides officers with training that includes a simple eight-question assessment tool, along with techniques for de-escalating a crisis. CIT has been implemented in many locations nationwide, and has been shown to reduce officer injury rates five-fold.[124] Many local law enforcement agencies report that it is even more effective than a traditional mobile crisis response team because police are typically first responders who are on the scene within 10 to 15 minutes.[125]

Educating the Public to Take Action to Prevent Suicide

Personal or cultural beliefs about suicide and mental illness, concerns about stigma and discrimination, and feelings of hopelessness can dissuade people from seeking help. Strategies that promote help-seeking behavior encourage people to reach out to family, friends, and resources in their communities when they are in need. These resources may include mental health services, peer support groups, community helpers such as promotoras, and faith-based organizations.

Community Gatekeepers

Gatekeepers are defined as those who regularly come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk and how to refer people to services that can help. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services and supports or whose risk factors may not be visible to health and mental health professionals.

Gatekeeper training targets a broad range of people in the community. The following is a list of possible community gatekeepers, including those identified in the National Strategy for Suicide Prevention:[13]

- School health personnel
- Employers and supervisors
- Clergy and faith-based community leaders
- Natural community helpers such as promotoras, senior center staff and volunteers, and staff from cultural resource centers
- Personnel and volunteers in older adult services and long-term care, including home health care, adult protective services, in-home support services, congregate or home delivered meals, and caregiver support services
- Hospice and nursing home staff and volunteers
- Personnel in group homes and licensed care facilities
- Emergency health care personnel, including first responders such as Emergency Medical Technicians.

The above list is general; training strategies

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 187 of 220

should consider the target population and ensure that individuals most likely to interact with those at risk in the community are included in the planning process. For example, in rural areas staff can be targeted in settings where individuals at high risk may be found, such as farm credit offices, unemployment offices, youth and women's shelters, DWI courts, and others.[50]

> *"Public policies that restrict access to lethal means and educate people about safe handling of lethal materials can save lives."*

Reducing Access to Lethal Means

Reducing access to lethal means is an important component of suicide prevention when it is integrated with other local, regional, and state-level activities that take into account target populations and consideration of methods that are frequently used in a particular locality.[126] Having a gun in the house is associated with higher risk of suicide among both adults and adolescents, and regions of the country with high rates of gun ownership also have higher overall suicide rates.[127,128] Using gun storage safety precautions, such as gun locks, storing guns unloaded, and storing ammunition in a separate, locked container, are associated with lower numbers of both suicide deaths as well as unintentional injuries.[128] Studies show that more restrictive firearm legislation, such as Child Access Prevention laws, has led to a significant decrease in suicide rates.[129,130] Public policies that restrict access to lethal means and educate people about how to safely handle potentially lethal materials – from firearms to medications – can save lives.

Information from the SPRC indicates that multiple efforts are under way in other states to address access to lethal means. Maine, New Hampshire, and Oregon provide educational materials and training about screening for access to lethal means in potentially suicidal patients who are in a primary care or emergency department setting, and how to provide counsel about reducing access to lethal means. Montana and Wyoming distribute free gun locks at community events.

There are examples of how reducing access to a particular form of lethal means can reduce the overall rate of suicide.[66] In England domestic coal-based gas once contained toxic levels of carbon monoxide, and many suicides occurred by this method. After the early 1960's, the gas was detoxified and the overall suicide rate declined by one-third. Installation of a barrier on the Duke Ellington Bridge in Washington, D.C. led to a reduction in the overall suicide rate in the city despite the presence of an equally high bridge one block away. National changes in firearms laws in Canada were followed by a reduction in suicide by firearms, particularly among youth; however, rates among older men, who are most likely to own guns, were not changed, and use of other methods by youths increased.

Most suicides by jumping occur from high-rise residential buildings.[131] However, in certain locations an iconic structure may attract a disproportionate number of suicide attempts.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 188 of 220

This phenomenon may develop in part from media coverage about suicides from these structures, romanticized ideas about what it is like to die by that method, or identification with symbolism behind that particular location or means of death.

Barriers designed to prevent suicide by jumping, such as the safety railings that have been erected on the Eiffel Tower and the Empire State Building, are effective in reducing or eliminating suicides at those sites. This issue has been the source of considerable local controversy in areas where suicides by jumping are a problem. Barriers can be controversial due to their cost relative to the number of lives lost, aesthetics, impacts on tourism, and perceptions about the inevitability of someone completing suicide another way if they are prevented from doing so by a barrier. However, one study of 515 individuals who were restrained from attempting suicide from the Golden Gate Bridge found that approximately 90 percent of them did not subsequently die by suicide or other violent means, suggesting that when suicide is deterred, the vast majority of individuals do not substitute another method.[132]

Approximately 1,200 people have lost their lives by jumping from the Golden Gate Bridge since it opened in 1937. The Marin County Coroner's Office reports that in the 10-year period between July 1997 and June 2007, there were 206 known suicide deaths by jumping from the Golden Gate Bridge.[133] Over 90 percent of the individuals who died were from Northern California, and half were from four of the six counties that are within the Golden Gate Bridge District (Marin, Napa, Sonoma, and San Francisco).

In response, the Golden Gate Bridge, Highway and Transportation District (the District) has implemented several strategies to reduce the number of suicides. These include 11 emergency/crisis counseling telephones along the sidewalk along with signage; traffic surveillance cameras that assist in detecting persons exhibiting suicidal behaviors; and suicide prevention training for bridge patrollers and District personnel. California Highway Patrol officers that patrol the roadway also receive suicide prevention training. The District estimates that these strategies have helped deter approximately two-thirds of individuals who intend to complete suicide by jumping from the Bridge. However, the District recognizes that these non-physical deterrence methods are not always successful. In July 2008, the District will release an environmental study to develop and evaluate options for a physical suicide deterrent system, such as higher railings or a barrier, for the Bridge.[134]

Public Awareness Campaigns, the Media, and the Entertainment Industry

Stigma around mental health is a deeply engrained part of our culture, and discrimination is evident in policy decisions ranging from health insurance coverage and employment to research priorities.[135] Negative portrayals of individuals with mental illness and sensational coverage of a tragic event contribute to stigmatizing attitudes in the general public, which often lead to discrimination. Unfortunately, these depictions of people with mental health problems as unpredictable and even dangerous are common in films, television, and the news media. When not countered with education and awareness about the facts of mental illness, these stories fuel people's fears and promote self-stigma among individuals with a mental illness diagnosis.

It is estimated that nearly two-thirds of those who have a diagnosable mental illness do not seek treatment because of fears of stigma and discrimination.[100] SAMHSA has launched an ongoing anti-stigma campaign that offers resources to states to develop their own targeted anti-stigma materials.136 Localized stigma and discrimination reduction projects are also under way in California through Mental Health Services Act funding. Development of a statewide suicide prevention campaign should complement local and national anti-stigma campaigns, peer-to-peer programs, and personal contact strategies that effectively increase awareness of suicide prevention and how to find help.

"It is estimated that nearly two-thirds of those who have significant mental health problems do not seek treatment because of fears of stigma and discrimination."

There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicidal behaviors, tailoring that message to include population-specific risk factors where appropriate. Such activities include designing messages that educate the public that suicide is preventable, raising awareness of the populations at risk, forging new and creative approaches to engage community partners, and promoting community-based support systems and cultural-specific ways of healing. Use of multiple media channels, including the ethnic media, is necessary to ensure that the message is far reaching. Linking with national campaigns, such as National Suicide Prevention and Awareness Week and National Depression Screening Day, should also be considered to maximize impact and exposure by reinforcing the messaging.

Public health has successfully used statewide social marketing campaigns to promote public awareness and to influence health behaviors on various topics. The California Tobacco Control Program (CTCP) was formed after Proposition 99 passed in 1988, providing California with the funds to initiate a comprehensive anti-tobacco program. The CTCP found that the most efficient way to reach its goal of decreasing tobacco-related deaths and disease is to implement initiatives statewide that seek to change social norms that influence individual behaviors.[137] The CTCP uses an approach of countering negative influences by depicting tobacco use as undesirable and socially unacceptable. The campaign also supports smoking cessation efforts through a helpline and community-based programs. Finally, the campaign includes a media education component to offset depictions of smoking as acceptable in movies and to counter tobacco industry advertising. Some of the results of the program include an increased desire and intention to quit among smokers, and the smoking prevalence in the state has declined by 33.6 percent since the program's inception.

When the number of stories about suicides increase, or a death is reported at length or featured prominently, the contagion effect can lead to an increase in suicides among susceptible individuals.[138,139] Guidelines have

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 190 of 220

been developed to inform the media about how to cover suicide incidents in a way that balances public safety with what is newsworthy.[140,141] Media coverage should be used as a positive tool to promote greater understanding of the risks and protective factors and how to get help.

National and state public health agencies have developed mechanisms to engage and educate the entertainment industry around health promotion and disease prevention. For example, Hollywood, Health & Society is a Norman Lear Center project that provides the entertainment industry with accurate and timely information for health storylines. The project is funded by the CDC, the National Cancer Institute, the Agency for Healthcare Research and Quality, the Health Resources Services Administration, and the California Department of Public Health. According to a 2001 survey, over half of regular television viewers reported that they learned about a disease or how to prevent it from watching a television show, and about one-third of regular viewers said they took some action after hearing about a health issue or disease on a television show. Finally, SAMHSA has begun to engage the entertainment industry via the VOICE Awards, an annual event that honors the television and movie industry for positive, recovery-oriented portrayals of mental illness.

Improving Program Effectiveness and System Accountability

Surveillance, Research, and Evaluation

Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. Due to the paucity of disaggregated data, there are gaps in knowledge about how suicide impacts certain racial and ethnic groups. While information is available about a number of effective and promising suicide prevention practices, much more needs to be learned about programs specifically designed to serve certain population groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda must be established to better design responsive policies and effective programs towards reducing the impact of suicide.

California is a large, diverse state with unique demographics. To strengthen suicide prevention, more needs to be known about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military service, and other factors related to identity. Many questions are yet unanswered about the causes and types of suicide, stages of suicidal behaviors (e.g., ideation, planning, attempt, and aftermath), and the impact of exposure to trauma such as adverse childhood events, historical trauma,[i] intergenerational conflicts,[j] and trauma history within an immigrant's country of origin. Understanding the role of multiculturalism and acculturation in the development of risk and protective factors in immigrant communities should be enhanced. More information is also needed about the relationship between suicide and postpartum depression, homicide, and other factors.

To increase knowledge on these issues, California needs to expand its capacity for surveillance, research, and evaluation on suicide and suicide prevention.

NOTES

[i] Historical trauma is the collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide.

[j] Intergenerational conflicts occur between generations and are related to the acculturation process of immigrant families.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 191 of 220

Surveillance is the continuous collection of information on the entire population for the purposes of monitoring and describing a problem. Research refers to limited, focused efforts to answer specific questions that cannot be answered easily through surveillance alone. Evaluation aims to determine how best to design and improve programs. These three approaches often overlap and interact, and all are necessary to support effective policies and programs.

> *"Accurate, complete, and disaggregated information needs to be accessible to the public and policy makers."*

Fortunately, California has the necessary partners and elements to take on this work. Multiple state agency databases exist that can be coordinated, connected, and enhanced to fill gaps in knowledge. California hosts a wealth of world-class research universities and institutes. Existing statewide surveys can be expanded to provide a broader picture of suicidal behavior. These surveys include the California Healthy Kids Survey for middle and high schools, the California Behavioral Risk Factor Surveillance and Youth Risk Behavior Surveillance instruments, the California Health Interview Survey, and others.

Accurate and complete information, including disaggregated racial and ethnic data, about suicide prevalence and prevention need to be widely accessible to the public and to policymakers to inform service and system improvements. Nationally, one persistent challenge is that the information that flows into reporting systems may not be uniform and may come from different sources. For example, the death certificate may ultimately be completed and signed by medical examiners or coroners, or by a public official in the legal system, which may result in differences in how suicide deaths are determined and recorded.[7] One solution to this inconsistency is to implement a single set of criteria for identifying and reporting suicide deaths that is widely used across systems. Another is to explore ways to expand or link the data systems that already exist, such as public health and vital statistics, coroner's office, hospitals, crisis centers, mental health, alcohol and drug programs, law enforcement and corrections, and schools.

An example of how data system linkage can increase knowledge about suicide is the CDC's National Violent Death Reporting System (NVDRS). California is one of 17 states currently participating. The California NVDRS links data from death certificates, police reports, and medical examiner or coroner reports to provide a better understanding of the incidents and risks of violent deaths, including suicide. Information from this database is used to identify trends and risk factors that can inform program and policy decisions to more effectively prevent suicide. NVDRS is also used to identify additional information that needs to be collected to pinpoint the factors associated with suicide. Some examples of how states have used the NVDRS include the following:

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 192 of 220

- Maryland changed its mental health outreach strategies when it learned that men have much higher rates of suicide and lower rates of contact with the mental health system than women.

- South Carolina instituted new screening protocols when it found that two-thirds of youths who committed suicide were involved in the juvenile justice system.

- Oregon now helps medical professionals identify patients at risk in response to findings that 37 percent of older adults visited a physician in the month prior to their suicide.

- Rhode Island now gathers information on specialties of physicians prescribing drugs, because data from its reporting system suggested that inadequate drug counseling may be implicated in suicide by overdose.

- California's use of the NVDRS has documented that the following risk factors were present in eight out of ten suicide deaths in three Bay Area counties, providing a basis for prevention planning:
  - 60 percent had a mental illness.
  - 30 percent documented a role of physical health problems.
  - 25 percent had made previous attempts or had spoken about their intent.
  - 25 percent reported problems with substance abuse.
  - 21 percent were having interpersonal problems with their partner or another individual.
  - Smaller percentages involved issues with employment, finances, and deaths in the family.

Efforts to expand statewide data systems should be complemented by strategies to increase local capacity for data collection, surveillance reporting, and information dissemination. As critical local partners in reporting on suicide deaths, coroners and medical examiners should be engaged in this process.

It is important to explore innovative and community-based research methods. For example, community participatory action research represents a true collaboration between researchers and the communities that are impacted by the research. Communities are integrally involved in identifying research questions, methods, and defining outcomes that are relevant to the community. Other research methods including longitudinal studies, qualitative studies such as focus groups, ethnography, and oral histories, are also important methods that can be developed to clarify how we can improve suicide prevention strategies tailored to local problems.

One promising model is death review teams, which provide a mechanism for communication and collaboration between different service systems that have important roles in a case. Child death review teams address concerns about the underreporting of child homicides by bringing together a multidisciplinary group that includes medical examiners and coroners to determine cause of death and improve surveillance.[142]

In California all 58 counties have a child death review team. The purpose of these teams is to prevent child abuse and neglect by understanding the factors that contribute

to each death and translating the learning into effective policies. Local teams are supported by a state team that oversees local activities, analyzes standardized local data into an annual report, and provides training on important confidentiality, procedural, and technical issues.

> *"Models for evaluating suicide prevention programs must be disseminated to increase the number of evidence-based practices in California."*

Some examples of policies that have changed as the result of child death review teams involve pool fencing and zero tolerance for guns on school property. Several counties have expanded the local child death review team into programs that also offer services and public education around issues such as bereavement, critical incident debriefing, and Sudden Infant Death Syndrome.

Currently, 25 counties have a Domestic Violence Fatality Review team. These teams are supported through a partnership between the California Health and Human Services Agency and the State District Attorney's Office. In 2000 a statewide advisory committee was formed that has developed a Review Team protocol to maintain consistency among review teams across the state. This committee now hosts regional trainings for local death review team participants. This effort has led to the development of a Risk Assessment Checklist for court judges and a database that tracks risk factors associated with domestic violence-related fatalities.

Counties may have other death review teams related to specific settings, such as deaths of individuals under treatment with the public mental health authority and in hospitals.

In San Francisco the recognition that 70 percent of suicide deaths were from traumatic self-injury (i.e., versus poisoning), along with the fact that two-thirds of those who died by suicide were in psychiatric treatment at the time of their death, led to the implementation of joint psychiatric and trauma service review teams at San Francisco General Hospital.[143] Suicide review teams created a feedback mechanism between different systems to improve care and ultimately prevent suicides in the city.

Finally, there is a need to identify and disseminate models for evaluating suicide prevention programs and activities to increase the number of evidence-based programs in California. This need includes collecting outcome measures that are consistent and relevant to improve programs and the experiences of service users. Culturally and linguistically appropriate approaches to suicide prevention need to be strengthened. Alongside statewide stigma reduction efforts, how the social norms change and their effects on rates of suicidal behavior and appropriate help-seeking behavior should be studied.

Several resources support the dissemination of evidence-based suicide prevention practices, such as the SPRC's Best Practices Registry and NREPP. The criteria required for inclusion in these registries (i.e., proven, promising, and emerging) has resulted in reliable sources of information about suicide prevention programs and practices, including whether they have been tested among diverse population groups.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 194 of 220

PART 3: STRATEGIC DIRECTIONS AND RECOMMENDED ACTIONS

The California Strategic Plan on Suicide Prevention serves as a platform for developing and offering a comprehensive range of strategies.

The Suicide Prevention Plan Advisory Committee formulated four strategic directions and corresponding recommended actions to set the course for reducing suicides and suicidal behaviors in California. These recommendations are grounded in the data and evidence offered in the two preceding chapters and were refined through the course of many rich discussions by the committee.

The *California Strategic Plan on Suicide Prevention* serves as a platform for developing and offering a comprehensive range of strategies, starting from prevention and early intervention to crisis services and aftercare, for children and youth to adults and older adults from diverse backgrounds. The programs and services generated from this plan must go beyond traditional approaches that solely depend upon identifying and treating individual risk factors. A population-based approach is essential and will require community-wide strategies and responsive organizational and environmental policies and practices. State and local partners spanning multiple disciplines and settings must work together to create the coordinated system of suicide prevention that is needed to make a difference in California. Lastly, ongoing research and evaluation must be viewed as a keystone element to continuously review and assess the efforts and overall direction. The Plan represents the initial five-year phase of this process.

It is fortuitous that this Plan is being released when there is a concerted effort underway through the Mental Health Services Act to focus more on health, wellness, resiliency and recovery, and to reduce stigma associated with mental illness. With so many lives at stake, the time is now to make suicide prevention a priority.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 195 of 220

About Core Principles, Strategic Directions, and Recommended Actions

Six core principles are embedded in all levels of planning, service delivery, and evaluation. The Plan is further organized by two levels of focus for suicide prevention: strategic directions and recommended actions.

Strategic directions are broad levels of focus that serve as the central aim that the more specific recommended actions address. These recommended actions are not an exhaustive list, but they emerged as priorities at this point in time to reduce suicide and its tragic consequences on individuals, families, and communities throughout California.

Taken together, the core principles, strategic directions, and recommended actions are intended to lay a foundation for a comprehensive system of suicide prevention that builds on existing infrastructure, expands capacity of co-existing systems, and identifies and fills gaps in services and programs.

Core Principle 1. *Implement culturally competent strategies and programs that reduce disparities.*

To be effective, systems, organizations, and services for suicide prevention must embrace behaviors, attitudes, and policies that are compatible with diverse belief systems and customs. A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic, and cultural groups that have been historically underserved. Planning and service improvement processes should involve members of the targeted racial, ethnic, and cultural groups.

Core Principle 2. *Eliminate barriers and increase outreach and access to services.*

Potential barriers must be addressed in designing and implementing outreach and service programs to ensure improved access for all Californians of diverse backgrounds and abilities. People who live in rural areas often must travel significant distances to access needed services. Many other individuals are isolated by physical and/or psychiatric disabilities, including age-related disabilities that render them homebound or marginalized from needed support systems. Information, programs, and materials need to be accessible and available in a variety of languages and formats. Programs and services must be accessible to those for whom English is not the primary language; with low literacy skills; and with vision, hearing, and cognitive impairments.

Core Principle 3. *Meaningfully involve survivors of suicide attempts; the family members, friends, and caregivers of those who have completed or attempted suicide; and representatives of target populations.*

Those who have survived a suicide attempt and their family members, friends, or caregivers bring important personal experience and unique perspectives to identifying service needs and gaps in the system and to delivering services. Additionally, when service improvements are under way that target specific populations, representatives of these groups must be involved in all aspects of planning and implementation. Peer support and education are invaluable components of a comprehensive system for suicide prevention.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 196 of 220

Core Principle 4. *Use evidence-based models and promising practices to strengthen program effectiveness.*

Many existing programs and practices have demonstrated effectiveness, broadly or within specific populations. Attention should be given to replicating and disseminating or adapting these effective program models and promising practices. Program design should include consideration of how evaluation can be used as a management tool to strengthen and improve programs. Evaluation data can be an invaluable tool to garner support for program implementation at all levels.

Many programs and providers currently offer needed and effective services to prevent suicide. Where such promising service or program models exist, the focus should be on coordinating and building upon their foundation towards the development of a more comprehensive system of suicide prevention.

Core Principle 5. *Broaden the spectrum of partners involved in a comprehensive system of suicide prevention.*

To align with the call to action that "Every Californian Is Part of the Solution," it is critical that long-term partnerships be developed with a broad range of partners that transcend the traditional mental health system. These partnerships may include the business community, ethnic and cultural community-based organizations, senior centers and aging services, the spiritual and faith communities, private foundations, schools and institutions of higher education, health and human service organizations, criminal and juvenile justice entities, and military partners, such as Veterans Affairs and the National Guard.

Core Principle 6. *Employ a life span approach to suicide prevention.*

Suicide prevention and intervention strategies should be targeted to Californians of all ages from children and youth, to adults, and older adults. The life span approach seeks to prevent a crisis from emerging as well as to provide prevention and early interventions to address problems long before they become acute.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 197 of 220

Strategic Direction 1: Create a System of Suicide Prevention

Increase collaboration among state and local agencies, private organizations, and communities by coordinating and improving suicide prevention activities and services throughout the state, from health and mental health promotion and prevention through crisis intervention.

Recommended Actions at the State Level

1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices, and community planning.

1.2 Engage a coalition of public partners to integrate, coordinate, enhance, and improve policies and practices that prevent suicide. These partners should include:

- Department of Aging
- Department of Alcohol and Drug Programs
- Department of Corrections and Rehabilitation
- Department of Education
- Department of Health Care Services
- Department of Managed Health Care
- Department of Mental Health
- Department of Public Health
- Department of Social Services
- Department of Veterans Affairs
- Managed Risk Medical Insurance Board
- National Guard

1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. The public and private partnerships should include:

- Community-based and ethnic-based organizations
- Community leaders
- Client, family, youth, and peer support advocacy groups
- Employers
- Health and mental health providers
- Insurance industry
- Local educational agencies and institutions of higher education
- Spiritual and faith-based organizations

1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues, and develop, adapt, and disseminate resources and other materials that address the topic.

1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level, and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 198 of 220

1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.

1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness, and recovery.

Recommended Actions at the Local Level

1.8 In each county, appoint a liaison to the state Office of Suicide Prevention, and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention issues. Membership should reflect a broad range of local stakeholders with expertise and experience with diverse at-risk groups, including:

- Local government and nonprofit agencies, such as mental health, public health, law enforcement, education, and Area Agencies on Aging
- Coroners and medical examiners
- Tribal representatives
- Survivors of suicide attempts and family members
- Mental health clients

1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council. The plan should:

- Identify measurable goals, objectives, and expected outcomes toward creating a comprehensive system of suicide prevention that includes health and mental health promotion through crisis interventions.
- Establish clear protocols for communication, including sharing confidential information, among systems and providers.
- Identify target population groups and strategies or an inclusive process for doing so.
- Create and monitor an effective crisis response system.
- Identify opportunities and embed and expand quality suicide prevention activities in local programs across systems.
- Provide for technical assistance to peer support programs, such as peer-run crisis respite centers and peer warm lines.
- Coordinate with the state Office of Suicide Prevention.
- Provide for periodic review of the county's progress and updates to the plan.
- Identify mechanisms to report on suicide prevention activities in existing county reporting structures, such as those for Mental Health Services Act components and county cultural competence reports.

1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.

1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders, and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 199 of 220

1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems.

1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.

1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office of Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention, and follow-up care across all service providers.

Recommended Actions at the State Level

2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote, and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

At a minimum, occupations selected for guidelines and curricula development and training should include:

- Primary care providers, including physicians and mid-level practitioners
- First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
- Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
- Social workers and other staff in older adult programs, in-home support services, adult and child protective services, and foster care
- Adult and juvenile system correction officers and probation and parole officers
- Administrators and faculty in elementary, middle, and high schools and in colleges and universities

Service and training guidelines should

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 200 of 220

include direction and recommendations for the following:

- Promoting health, mental health, and prevention principles
- Addressing barriers related to mental health stigma and discrimination
- Increasing understanding of protective and risk factors, including the role of age, sex, culture, race, ethnicity, and gender identity and sexual orientation in suicide prevention
- Improving suicide risk assessment and treatment
- Establishing specific actions for follow-up care after a suicide attempt and/or discharge from an emergency room, urgent care center, hospital, or at the end of a visit with a physician or health care staff
- Reviewing guidelines in health insurance plans to ensure effective response and services to assess and address suicide risk or suicidal behavior
- Implementing promising practices for law enforcement, such as crisis intervention teams
- Considering how to promote incentives for community organizations to provide suicide prevention training and to employ trained gatekeepers

2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, graduate

2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.

Recommended Actions at the Local Level

2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training, and the models, including peer support, which will be used for training. Using an inclusive process for input, develop and implement training plans that meet these targets.

2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 201 of 220

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

Raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behaviors.

Recommended Actions at the State Level

3.1 Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and that address warning signs, suicide risk and protective factors, and how to get help.

3.2 Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

3.3 Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness, and mental health services that support suicide prevention efforts.

3.4 Promote information and resources about strategies that reduce access to lethal means, such as gun safety education and increasing compliance with existing gun safety laws, safe medication storage, and physical and non-physical deterrent systems on bridges or other high structures.

3.5 Disseminate and promote models for suicide prevention education for community gatekeepers.

Recommended Actions at the Local Level

3.6 Build grassroots outreach and engagement efforts to coordinate with and tailor the statewide suicide prevention education campaign and activities to best meet community needs.

3.7 Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.

3.8 Educate family members, caregivers, and friends of those who have attempted suicide, individuals who have attempted suicide, and community helpers to recognize, appropriately respond to, and refer people demonstrating acute warning signs.

3.9 Promote and provide suicide prevention education for community gatekeepers.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 202 of 220

3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.

3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

DImprove data collection, surveillance, and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations.

Recommended Actions at the State Level:

4.1 Develop a California surveillance and research agenda on suicide, suicide attempts, and suicide prevention to support data-driven policies and evidence-based programs.

4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods, and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to, and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.

Recommended Actions at the Local Level:

4.5 Increase local capacity for data collection, reporting, surveillance, and dissemination to inform prevention and early intervention program development and training.

4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.

4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory council could use the reports to inform local policy action recommendations. Members of the case review teams should include representatives of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.

4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 204 of 220

PART 4: NEXT STEPS

The *California Strategic Plan on Suicide Prevention* has identified four major strategic directions and numerous recommended actions to reduce the number of suicide deaths and the incidence of suicidal behaviors in California. The plan calls for a substantial coordinated effort by multiple partners to identify and successfully achieve the necessary program, policy, and system improvements. Many of the recommendations require a long-term effort; others can be implemented immediately. The purpose of this section is to outline initial steps that should be taken to implement the recommendations in this plan.

The Suicide Prevention Plan Advisory Committee recognized that to succeed in both the short and long term, it is essential during the first phase of implementation to establish a solid foundation upon which to build. Further, the Advisory Committee acknowledged the need to be deliberate and sequential in implementing the recommendations (e.g., the need to enhance the capacity of the workforce before launching a major campaign that would increase the demand for services). Lastly, the Advisory Committee implored that the funding to support the ongoing services be at a sufficient and sustained level.

Success will be achieved through a collective and well-integrated effort; it cannot be solely dependent upon one funding source nor can the responsibility be shifted to any one entity. The theme, "Every Californian Is Part of the Solution," must ring true throughout the implementation of the strategic plan if suicidal behaviors are to be decreased and lives are to be saved. As a result, the implementation of the recommended actions, and the next steps will be the responsibility of an array of state, local, public, and private partners.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 205 of 220

The Office of Suicide Prevention will serve as a coordination point for addressing many of the recommended actions in this plan. Leadership and support from other public agencies and private organizations must also play a paramount role. Thus, in conjunction with a number of key partners, the Office of Suicide Prevention will develop a detailed work plan to initiate its operation.

The DMH and the MHS Oversight and Accountability Commission (OAC), with support from the California Mental Health Directors Association (CMHDA), have recommended that counties direct approximately $14 million in MHSA funds each year for four years to support a statewide suicide prevention effort. A portion of the funding has been earmarked for Student Mental Health Initiative[k] funding for K-12, community colleges, and universities.

To launch this concerted effort to prevent suicide and suicidal behavior in California, the following activities should be considered for the initial five-year implementation phase that will provide a foundation for future work.

Strategic Direction 1: Create a System of Suicide Prevention

State Level

1.A Staff the Office of Suicide Prevention established within the California Department of Mental Health on February 6, 2008.

1.B Develop and issue an action plan that includes an assessment of the current level of activity and detection of major gaps, and identifies objectives toward implementing the initial activities described in this "Next Steps" section.

1.C Establish a technical assistance infrastructure of regional working groups/learning collaboratives, consultation, training, and other support methods, and a resource center to support local suicide prevention systems and efforts.

1.D Establish a statewide coalition of state-level organizations and public and private partners to better address the integration of effective suicide prevention policies, practices, and programs into existing service systems. The initial coalition will include the state agencies identified in Recommended Action 1.2 and be expanded to include the public and private partners identified in Recommended Action 1.3.

1.E Assess the current status of coverage and accreditation for suicide prevention hotlines in California. Beginning with call centers that are members of the National Lifeline, build a consortium of accredited suicide prevention hotlines statewide to expand access to standardized services throughout the state and to ensure full multilingual, cultural, and age-specific crisis coverage for all Californians.

1.F Provide technical support to expand functions for accredited suicide prevention hotline centers, such as training centers for various occupations and professions, including peer support providers and after-care service providers.

NOTES

[k] The Student Mental Health Initiative is aimed to strengthen mental health for students in both K-12 and higher education through training, mental health education, peer support, violence prevention and suicide prevention activities in local education agencies and higher education campuses.

[l] 211 lines provide information about community services and information related to health and human services.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 206 of 220

1.G Enhance the database for monitoring, tracking, evaluating, and reporting suicide prevention hotline calls in California. At minimum, collect information about calls and outcomes by age, sex, county location, and language.

1.H Provide technical assistance to expand or link accredited hotlines to additional venues and formats, including the Internet, 211 lines[l], Web-based self-help services, and other age-appropriate means to improve access to information on local suicide prevention and early intervention services.

1.I Provide technical support to counties to conduct a comprehensive assessment of suicide prevention services.

1.J Link and provide support to county-level advisory councils dedicated to developing the local coordinated suicide prevention system. Establish and maintain a collaborative relationship among the state and county liaisons.

Local Level

1.K Appoint a liaison to the state Office of Suicide Prevention in each county.

1.L Convene or build upon an existing entity to establish a county suicide prevention advisory council that is dedicated to developing the local coordinated suicide prevention system.

1.M Design and implement a comprehensive assessment of the existing county suicide prevention services and supports and the detection of major gaps that will inform the development of the local suicide prevention action plan, from health and mental health promotion through crisis intervention and after care.

1.N Develop a local suicide prevention action plan through an inclusive community process that includes review of the comprehensive assessment, identification of short-term and long-term objectives, establishment of milestones, and completion of a work plan. Establish the baseline of the targeted policy, program, and system improvements.

1.O Assess capacity of local or, where appropriate, regional accredited suicide prevention hotline(s) and take steps needed to achieve accreditation or build the capacity (e.g., as training centers or after-care service providers; expand or link to web-based formats) of already accredited hotlines.

Strategic Direction 2: Implement Training and Workforce Enhancements to Prevent Suicide

State Level

2.A Assess the current criteria and standards for service and training guidelines that address suicide prevention, early intervention, treatment, and suicide attempt follow-up care for California's diverse population. Begin with a review of the various occupations and professions identified in this plan to determine the first cohort of training programs to be assessed and enhanced. Identify opportunities for training program enhancements and work cooperatively with appropriate agencies to implement needed improvements.

2.B Convene expert work groups to recommend, develop, and broadly promote standard service and training guidelines and curricula for targeted service providers, including peer support providers, in California. Review licensing and credentialing processes to assess viability of new training requirements.

2.C Coordinate and review surveys on local training needs. Include in the Office of Suicide Prevention's action plan methods for supporting counties in addressing and providing the necessary training, utilizing distance-learning modalities, online services, and other effective methods. Secure resources and partnerships to expand available support.

2.D Deliver train-the-trainer sessions for targeted service providers.

Local Level

2.E Review local MHSA Workforce Education and Training component assessments to identify elements relevant to suicide prevention efforts. To supplement information, survey suicide prevention training programs and needs and assess gaps. In conjunction with the state efforts, set local training targets for selected occupations, develop a plan with responsible parties to meet those targets and a process to measure progress.

2.F Disseminate and promote service standards and training guidelines. Design and implement an inclusive community process to adapt guidelines to better serve local needs as necessary.

Strategic Direction 3: Educate Communities to Take Action to Prevent Suicide

State Level

3.A In conjunction with any existing social marketing efforts, such as stigma and discrimination reduction activities, develop and implement an age-appropriate, multi-language education campaign and messages specifically designed and pilot-tested to positively influence attitudes about the preventability of suicide, to increase appropriate help-seeking behaviors, and to reduce suicidal behaviors.

3.B Obtain the necessary social marketing consultation to design, test, and promote the suicide prevention messages in ways that will benefit target populations at risk for suicide. Develop, test, and produce accompanying outreach and educational materials.

3.C Support local efforts to engage and educate the media by disseminating selected resources from national and other suicide prevention organizations.

3.D Identify a strategy for reducing access to lethal means in California.

3.E Identify and disseminate models that counties can use to implement suicide prevention gatekeeper education.

3.F Conduct regional training to build local capacity for peer support programs.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 208 of 220

3.G Design, produce, and maintain a web page for the Office of Suicide Prevention that provides links to the many sources of reliable information. Identify and develop additional new information needed to appropriately address the needs of all Californians.

Local Level

3.H Coordinate local outreach, awareness, and education activities with other social marketing campaign efforts as a means to expand suicide prevention messages and information in multiple languages.

3.I Design and implement a strategy to better engage and educate the local media on the importance of appropriate and responsible reporting of suicide deaths and suicide prevention information.

3.J Design a community education plan that may include:

- Developing a community calendar of events and activities promoting suicide prevention awareness and education
- Identifying opportunities to integrate suicide prevention information into ongoing services in education, primary care, older adult, first responder, faith community, and other systems
- Localizing national and state suicide prevention events

3.K Reach out to community gatekeepers, including staff and volunteers providing home-based services, to increase their awareness and participation in suicide prevention efforts.

3.L Develop and widely disseminate a directory of local suicide prevention services and supports in multiple formats. Design a process to ensure that the directory is kept up-to-date.

3.M Foster the development of peer support programs, including support groups and networks.

Strategic Direction 4: Improve Suicide Prevention Program Effectiveness and System Accountability

State Level

4.A Working collaboratively with other local, state, and national entities develop a California-specific research agenda, including surveillance and evaluation, on suicide attempts and deaths and suicide prevention to support more effective policies and programs. Design a process to identify priority activities from a comprehensive review of multiple data sources and an inclusive decision-making process.

4.B Work to improve the collection and reporting of data as well as the systems for surveillance for a better understanding of the suicide trends and rates, and the impact of protective and risk factors among California's diverse population groups that can lead to more appropriate policies and programs. Target research activities in key areas, such as policies and programs appropriate for specific ethnic, cultural, and age groups, that are gender-specific, that address trauma and other factors, and that have effective application in multiple settings.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 209 of 220

4.C Develop an evaluation component to track and monitor the statewide effort, including a system for monitoring and tracking national, state, and local policy changes and system improvements leading to a reduction in suicidal behaviors and suicide deaths in California.

4.D Develop and disseminate data reports on special topics and specific target populations by age, sex, culture, race, ethnicity, and other factors to enhance programs and service delivery.

Local Level

4.E Assess local data sources and reporting processes pertinent for suicide prevention and develop and implement a strategy to enhance data collection across systems.

4.F Coordinate with the state Office of Suicide Prevention to build local capacity for program evaluation, including community participatory research methods.

4.G Complete an inventory of existing death review teams serving the county. In coordination with the local suicide prevention advisory council, build the capacity for conducting a suicide death review process in each county and provide for regular reporting on suicide deaths to the suicide prevention advisory council.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 210 of 220

REFERENCES

[1] Muehlenkamp, J.J. and Gutierrez, P.M. (2007). Risk for suicide attempts among adolescents who engage in non-suicidal self-injury. *Archives of Suicide Research*, 11, 69-82.

[2] Silverman, M.M., A.L. Berman, N.D. Sanddal, P.W. O-Carroll, and T.E. Joiner. (2007). Rebuilding the tower of Babel: A revised nomenclature for the study of suicide and suicidal behaviors; Part 2: Suicide-related ideations, communications, and behaviors. *Suicide and Life-Threatening Behavior*, 37(3), June 2007, 264-277.

[3] Rudd, M.D., A.L. Berman, T.E. Joiner, M.K. Nock, M.M. Silverman et al. (2006). Warning signs for suicide: Theory, research, and clinical implications. *Suicide and Life-Threatening Behavior*, 36(3), June 2006, 255-262.

[4] Gray, S.M., and M.W. Otto. (2001). Psychosocial approaches to suicide prevention: applications to patients with bipolar disorder. *Journal of Clinical Psychiatry*; 62 (supplement 25): 56-64.

[5] Evans, W.P., P. Owens, and S.C. Marsh. (2002). Environmental factors, locus of control, and adolescent suicide risk. *Child and Adolescent Social Work Journal*, 22(3-4), August 2005, 301-319.

[6] Dube, S.R., R.F. Anda, V.J. Felitti, D.P. Chapman, D.F. Williamson, and W.H. Giles. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences study. *Journal of the American Medical Association*, 286(24). 3089-3096.

[7] Goldsmith, S.K., T.C. Pellmar, A.M. Kleinman, and W.E. Bunney (Eds). (2002). *Reducing Suicide: A National Imperative*. Washington DC: The National Academies Press.

[8] Goldsmith, S.K. (2001). *Risk factors for suicide: Summary of a workshop*. Washington DC: National Academy press.

[9] *California Office of Statewide Health Planning and Development, Patient Discharge Data*. Retrieved from California Department of Public Health, Epidemiology and Prevention for Injury Control Branch Web site: http://www.dhs.ca.gov/EPICenter

[10] Centers for Disease Control and Prevention. (2006). Homicides and Suicides --- National Violent Death Reporting System, United States, 2003-2004. *Morbidity and Mortality Weekly Report*, 55(26), July 2006, 721-724.

[11] Chapman, D.P. and G.S. Perry. (2008). Depression as a major component of public health for older adults. *Preventing Chronic Disease*, 5(1). Retrieved from http://www.cdc.gov/pcd/issues/2008/jan/07_0150.htm

[12] State of California, Department of Finance. (2007). Population Projections for California and Its Counties 2000-2050, by Age, Gender and Race/Ethnicity, Sacramento, California, July 2007.

[13] U.S. Department of Health and Human Services. (2001). National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD.

[14] Centers for Disease Control and Prevention. (2007). Suicide trends among youths and young adults aged 10-24 years – United States, 1990-2004. *Morbidity and Mortality Weekly Report*, 56(35), September 2007, 905-908.

[15] University of California. (2006). *Student Mental Health Committee Final Report*, Office of the President, September, 2006.

[16] Garcia, J., J. Adams, L. Friedman, and P. East. (2002). Links between past abuse, suicide ideation, and sexual orientation among San Diego college students. *Journal of American College Health*, 51(1), 9-14.

[17] U.S. Dept. of Health and Human Services. (2005). Surgeon General's Workshop on Women's Mental Health. *Workshop Report*, Nov 30-Dec 1, Rockville, MD.

[18] Bradford, J., C. Ryan, and E.D. Rothblum. (1994). National Lesbian Health Care Survey: Implications for mental health care. *Journal of Consulting and Clinical Psychology*, 62(2), 228-242.

[19] Knox, K.L. and E.D Caine. (2005). Establishing priorities for reducing suicide and its antecedents in the United States. *American Journal of Public Health*, 95(11), 1898-1903.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 211 of 220

[20] *Web-based Injury Statistics Query and Reporting System*. (2005). Retrieved from National Center for Injury Prevention and Control, CDC Website: http://www.cdc.gov/ncipc/wisqars/default.htm

[21] Pirkis, J. and P. Burgess. (1998). Suicide and recency of contact with health care: A systematic review. *British Journal of Psychiatry*. 173, 462-475.

[22] Willis, L.A., D.W. Coombs, P. Drentea, and W.C. Cockerham. (2003). Uncovering the mystery: Factors of African American suicide. *Suicide and Life-Threatening Behavior*, 33(4), Winter 2003, 412-429.

[23] Centers for Disease Control and Prevention. (2006). Youth Risk Behavior Surveillance – United States, 2005. *Morbidity and Mortality Weekly Report*, 55(SS-5), June 2006, 9-10.

[24] Fortuna, L. R., Perez, D. J., Canino, G., Sribney, W., and Alegria, M. (2007). Prevalence and correlates of lifetime suicidal ideation and suicide attempts among Latino subgroups in the United States. *Journal of Clinical Psychiatry*, 68(4), 572-581.

[25] National Institute of Mental Health. (2003). *In Harm's Way: Suicide in America*. NIH Publication No. 03-4594. Printed in January 2001; revised April 2003.

[26] Rihmer, Z. and K. Kiss. (2002). Bipolar disorders and suicidal behaviour. *Bipolar Disorders*, 4 (supplement 1): 21-25.

[27] Jamison, K.R. (2001). Suicide and bipolar disorders. *Annals of the New York Academy of Sciences*, 932, 24-43

[28] Palmer, B.A., V.S. Pankratz, and J.M. Bostwick. (2005). The lifetime risk of suicide in schizophrenia: a reexamination. *Archives of General Psychiatry*, 62, March 2005: 247-253.

[29] Raymont, V. (2001). Suicide in schizophrenia – how can research influence training and clinical practice? *Psychiatric Bulletin*, 25, 46-50.

[30] Substance Abuse and Mental Health Services Administration. (2006). Suicidal thoughts, suicide attempts, and substance use among adults. *The OAS Report*, 34, SAMHSA Office of Applied Studies, Rockville, MD.

[31] Dumond, R. W. (2003). Confronting America's most ignored crime problem: The prison rape elimination act of 2003. *Journal of the American Academy of Psychiatry and the Law*, 31, 354-360.

[32] Lyon, D. (2007). Helping mentally ill criminals: Jailing offenders with mental illnesses serves no one, but new policies and funding are bringing about needed changes. *State Legislatures*. National Conference on State Legislatures, April, 2007.

[33] U.S. Department of Justice. 2005. Suicide and homicide in state prisons and local jails. Bureau of Justice Statistics Special Report, August 2005, NCJ 210036, Washington, DC.

[34] Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P.J., Cheadle, A., Elmore, J.G., and Koepsell T. D. (2007). Release from prison- A high risk of death for former inmates. *New England Journal of Medicine*, 365(2), 157-165.

[35] Pratt D., Piper, M., Appleby, L., Webb, R., & Shaw, J. (2006). Suicide in recently released prisoners: A population-based cohort study. *Lancet*, 368(9546), 1492-1493.

[36] Lund, L.E. and S. Smorodinsky. (2001). Violent death among intimate partners: A comparison of homicide and homicide followed by suicide in California. *Suicide and Life Threatening Behavior*, 31(4), Winter 2001, 451-459.

[37] Kaplan, M. S., Huguet, N., McFarland, B. H., & Newsom, J. T. (2007). Suicide among male veterans: A prospective population-based study. *Journal of Epidemiology and Community Health*, 61, 619-624.

[38] U.S. Department of Veterans Affairs. (2007). *Healthcare Inspection: Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*. Report No. 06-03706-126, May 10, 2007. VA Office of the Inspector General, Washington, D.C.

[39] Zivn, J., M. Kim, J.F. McCarthy, K.L. Austin, K.J. Hoggatt, H. Walters, and M. Valenstein. (2007). Suicide mortality among individuals receiving treatment for depression in the Veterans Affairs Health System: Associations with patient and treatment setting characteristics. *American Journal of Public Health*. 97(12), 2193-2198.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 212 of 220

[40] Hoge, C.W., J.R. Carr, J. Gardner, Potter. (2004). Suicide Surveillance in the U.S. Military – Reporting and Classification Biases in Rate Calculations. *Suicide and Life-Threatening Behavior*, 34(3), Fall 2004, 233-241.

[41] Retrieved from U.S. Department of Veterans Affairs Web site: http://www1.va.gov/homeless/page.cfm?pg=1

[42] Christensen, R.C. (2006). Where is the research on homeless persons and suicide? *Psychiatric Services*. 57(4), April, 2006.

[43] Desai, R. A., Liu-Mares, W., Dausey, D. J., & Rosenheck, R. A. (2003). Suicidal ideation and suicide attempts in a sample of homeless people with mental illness. *The Journal of Nervous and Mental Disease*, 191(6), 365-371.

[44] Eynan, R., Langley, J., Tolomiczenko, G., Rhodes, A. E., Links, P. Wasylenki, D., et al. (2002). The association between homeless and suicidal ideation and behaviors: Results of a cross-sectional survey. *Suicide and Life Threatening Behavior*, 32(4), 418-427.

[45] Prigerson, H. G., Desai, R. A., Liu-Mares, W., & Rosenheck, R. A. (2003). Suicidal ideation and suicide attempts in homeless mentally ill persons : Age-specific risks of substance abuse. *Social Psychiatry and Psychiatric Epidemiology*, 38, 213-219.

[46] Yoder, K.A. (1999). Comparing suicide attempters, suicide ideators, and nonsuicidal homeless and runaway adolescents. *Suicide and Life Threatening Behavior*. 29(1), Spring 1999, 25-36.

[47] Nasseri, K. (2007). Mortality in first generation white immigrants in California, 1989-1999. *Journal of Immigrant Minority Health*, Published online July 28, 2007.

[48] Kposawa, A.J., J.P. McElvain, and K.D. Breault. (2008). Immigration and suicide: The role of marital status, duration of residence, and social integration. *Archives of Suicide Research*, 21, 82-92.

[49] Gamm, L.D., L. Hutchison, B.J. Dabney, and A. Dorsey, eds. (2003). Rural Healthy People 2010: Volume 2. College Station, TX: Texas A&M University System Health Science Center.

[50] Suicide Prevention Action Network. (2005). Lost in rural America. *Advancing Suicide Prevention*, 1, July/August 2005, 16-20.

[51] Fiske, A., M. Gatz, and E. Hannell. (2005). Rural suicide rates and availability of health care providers. *Journal of Community Psychology*, 33(5), 537-543.

[52] Silenzio, V.M.B., J.B. Pena, P.R. Duberstein, J. Cerel, and K.L. Knox. (2007). Sexual orientation and risk factors for suicidal ideation and suicide attempts among adolescents and young adults. *American Journal of Public Health*, 97(11), 2017-2019.

[53] Russell, S.T. & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91(8), 1276-1281.

[54] D'Augelli A.R., A.H. Grossman, N.P. Salter, J.J. Vasey, M.T. Starks, and K.O. Sinclair. (2005). Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide and Life Threatening Behavior*, 35(6), December 2005, 646-660.

[55] Ramedi, G., S. French, M. Story, M.D. Resnick. (1998). The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, 88(1).

[56] Cochran, S.D., V.M. Mays, M. Alegria, A.N. Ortega, and D. Takeuchi. (2007). Mental health and substance abuse disorders among Latino and Asian American Lesbian, Gay, and Bisexual Adults. *American Psychological Association*, 75(5), 785-794.

[57] Paul, J.P., J. Catania, L. Pollack, J. Moskowitz, J. Canchola, T. Mills, D. Binson, and R. Stall. (2002). Suicide attempts among gay and bisexual men: Lifetime precedents and antecedents. *American Journal of Public Health*, 92(8), August 2002, 1338-1345.

[58] Kipke, M.D., K. Kubicek, G. Weiss, C. Wong, D. Lopez, E. Iverson, and W. Ford. (2007). The health and health behaviors of young men who have sex with men. *Journal of Adolescent Health*, 40(2007), 342-350.

[59] Clements-Nolle, K., R. Marx, and M. Katz. (2006). Attempted suicide among transgender persons: The influence of gender-based discrimination and victimization. *Journal of Homosexuality*, 51(3), 53-69.

[60] Lock, J. and H. Steiner. (1999). Gay, Lesbian, and Bisexual youth risks for emotional, physical, and social problems: Results from a community-based survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38:3, March 1999, 297-304.

[61] Lindahl, V., J.L. Pearon, and L. Colpe. (2005). Prevalence of suicidality during pregnancy and the postpartum. *Archives of Women's Mental Health*. 8(2), June 2005, 77-87.

[62] Appleby, L., P.B. Mortensen, and E.B. Farragher. (1988). Suicide and other causes of mortality after postpartum psychiatric admission. *British Journal of Psychiatry*. 173, 209-211.

[63] Chaudron LH, Kitzman HJ, Szilagyi PG, Sidora-Arcoleo K, Anson E. (2006). Changes in maternal depressive symptoms across the postpartum year at well child care visits. *Ambulatory Pediatrics*. 6(4), Jul-Aug 2006, 221-224.

[64] Joseffson, A. and G. Sydsjo. (2007). A follow-up study of postpartum depressed women: Recurrent maternal depressive symptoms and child behavior after four years. *Archives of Women's Mental Health*, 10(4), 141-145.

[65] Simon, T.R., A.C. Swann, K.E. Powell, L.B. Potter, M. Kresnow, and P.W. O'Carroll. (2001). Characteristics of impulsive suicide attempts and attempters. *Suicide and Life Threatening Behavior*, 32, 49-59.

[66] Daigle, M. (2005). Suicide prevention through means restriction: Assessing the risk of substitution, a critical review and analysis. *Accident Analysis and Prevention*, 37(2005) 625-632.

[67] White House. (2007). Report to the President on Issues Raised by the Virginia Tech Tragedy. June 13, 2007, Washington, D.C.

[68] Kposawa, A.J., and J.P. McElvain. (2006). Gender, place, and method of suicide. *Social Psychiatry and Psychiatric Epidemiology*, 41, 435-443

[69] Centers for Disease Control and Prevention. (2007). Unintentional poisoning deaths – United States, 1990-2004. *Morbidity and Mortality Weekly Report*, 56(05), February 2007, 93-96.

[70] Centers for Disease Control and Prevention. (2007). Increases in age-group-specific injury mortality – United States, 1990-2004. *Morbidity and Mortality Weekly Report*, 56(49), December 2007, 1281-1284.

[71] McIntosh, J. (2006). *U.S.A. Suicide: 2003 Official Final Data*. Retrieved from the American Association of Suicidology Web site: http://www.suicidology.org/associations/1045/files/2003data.pdf

[72] Corso, P. S., Mercy, J. A., Simon, T. R., Finkelstein, E. A., & Miller, T. R. (2007). Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *American Journal of Preventative Medicine*, 32(6), 474-482.

[73] Suicide Prevention Resource Center. *California Suicide Prevention Fact Sheet*. Retrieved July 28, 2008 from http://www.sprc.org

[74] U.S. Department of Health and Human Services. (2001). National Strategy for Suicide Prevention: Goals and Objectives for Action. Rockville, MD.

[75] Suicide Prevention Advocacy Network-California. (2003). *Strategic Plan on Suicide Prevention*. Retrieved from http://www.span-california.org/

[76] Maris, R., Berman, A., & Silverman, M. (2000). *Treatment and prevention: Comprehensive textbook of suicidology*. (pp. 528-535). New York, NY: The Guilford Press.

[77] Raingruber, B. (2003). Gaps in service in the recognition and treatment of depression and suicidal ideation within a four-county area. *Perspectives in Psychiatric Care*, 39(4), Oct-Dec 2003, 151-162.

[78] Westray, H. *The Maryland Suicide Prevention Model*. Retrieved January 2, 2008 from Suicide Prevention Resource Center Web site: http://www.sprc.org

[79] Katakoa, S., B.D. Stein, E. Nadeem, and M. Wong. (2007). Who gets care? Mental health service use following a school-based suicide prevention program. *Journal of the American Academy of Child Adolescent Psychiatry*, 46(10), 1341-1348.

[80] Baraff, L.J., N. Janowicz, and J.R. Asarnow. (2006). Survey of California emergency departments about practices for management of suicidal patients and resources available for their care. *Annals of Emergency Medicine*. 48(4), October 2006, 452-458.

[81] Timmermans, S. (2005). Suicide determination and the professional authority of Medical Examiners. *American Sociological Review*, 70, 311-313.

[82] Diesenhammer, E. A., Huber, M., Kemmler, G., Weiss, E. M, & Hinterhuber, H. (2007). Psychiatric hospitalizations during the last 12 months before suicide. *General Hospital Psychiatry*, 29, 63-65.

[83] Stroul, B. (2007). Integrating mental health services into primary care settings - Summary of the special forum held at the 2006 Georgetown University Training Institutes. Washington, DC: *Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health*.

[84] Gaynes, B.N., S.L. West, C.A. Ford, P. Frame, J. Klein, and K.N. Lohr. (2004). Screening for suicide risk in adults: A summary of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, 140(10), May 2004, 822-835.

[85] U.S. Preventive Services Task Force. (2002). *Screening for Depression: Recommendations and Rationale*. Retrieved from Agency for Healthcare Research and Quality, Rockville, MD Web site: http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm

[86] Georgiopoulos, A.M., T.L. Bryan, P. Wollan, and B.P. Yawn. (2001). Routine screening for postpartum depression. *Journal of Family Practice*. 50(2), February 2001, 117-122.

[87] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and National Institutes of Health, National Institute of Mental Health.

[88] Kalafat, J., Gould, M., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes; Part 1: Nonsuicidal crisis callers. *Suicide and Life-Threatening Behavior*, 37(3), 322-337.

[89] Gould, M. S., Kalafat, J., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes; Part 2: Suicidal Callers. *Suicide and Life-Threatening Behavior*, 37(3), 338-352.

[90] Joiner, T., Kalafat, J., Draper, J., Stokes, H., Knudson, M., Berman, A. L., el. al. (2007). Establishing standards for the assessment of suicide risk among callers to the National Suicide Prevention hotline. *Suicide and Life-Threatening Behavior*, 37(3), 353-365.

[91] National Institute of Mental Health. (2004). *Pragmatic Considerations of Culture in Preventing Suicide*. Meeting Summary, Philadelphia, PA: September 9, 2004 –September 10, 2004. Retrieved from National Institute of Mental Health Web site: http://www.nimh.nih.gov

[92] Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916.

[93] U.S. Dept of Health and Human Services. (n.d.) *Depression and Anxiety Prevention for Older Adults*. Older Americans Technical Assistance Center. Professional Reference Series, *Depression and Anxiety: Volume 1*. Rockville, MD.

[94] Bartels, S.J., F.C. Blow, L.M. Brockman, and A.D. Van Citters. (2005). *Substance abuse and mental health among older Americans*. A report of the Older American Substance Abuse and Mental Health Technical Assistance Center, SAMHSA, Rockville, MD.

[95] National Institute of Mental Health. (2003). *Older Adults: Depression and Suicide Facts*. Retrieved September 1, 2007 from National Institute of Mental Health Web site: http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm

[96] NREPP: *National Registry for Evidence Based Programs and Practices*. (n.d.) Retrieved from Substance Abuse and Mental Health Services Administration Web site: http://www.nrepp.samhsa.gov. Rockville, MD.

[97] Bruce, M.L., Ten Have, T.R., Reynolds, C.F. III, Katz, K.K., Schulberg, H.C., Mulsant, B.H., Brown, G.K., McAvay, G.J., Pearson, J.L., and Alexopoulos, G.S. (2004). Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *Journal of the American Medical Association*, 291(9), 1081-1091.

[98] Karlin, B.E., and K. Humphreys. (2007). Improving Medicare coverage of psychological services for older Americans. *American Psychologist*, 62(7): 637-649.

[99] Van Tosh, L. and del Vecchio, P. (2000). *Surgeon General's Report on Mental Health, Chapter 4*. U.S. Dept. of Health and Human Services. Rockville, MD.

[100] U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and National Institutes of Health, National Institute of Mental Health.

[101] Lopez, A. (2002). Demographics of California counties: A comparison of 1980, 1990, and 2000 Census data. *Race and ethnicity in California: Demographic Report Series, No. 9, June 2002*, Center for Comparative Studies in Race and Ethnicity, Stanford University.

[102] Lopez, A. (2002). Citizenship and language use in California: Profiles from the 2000 Census supplementary survey. *Race and ethnicity in California: Demographic Report Series, No. 6, February 2002*, Center for Comparative Studies in Race and Ethnicity, Stanford University.

[103] Lopez, A. (2003). The foreign-born in California: Place of origin, region of residence, race, time of entry, and citizenship status. *Race and ethnicity in California: Demographic Report Series – No.15 (June 2003)*, Center for Comparative Studies in Race and Ethnicity, Stanford University.

[104] U.S. Department of Health and Human Services. (n.d.). Retrieved January 9, 2008 from Indian Health Services Community Suicide Prevention Web site: http://www.ihs.gov/NonMedicalPrograms/nspn/index.cfm

[105] One Sky Center. (2006). *A guide to suicide prevention for American Indian and Alaska Native communities*. A publication of the American Indian/Alaska Native National Resource Center. Portland, OR.

[106] U.S. Department of Health and Human Services. (2005). *Suicide Prevention among Native American Youth*. Testimony Before the Indian Affairs Committee United States Senate. Statement of Surgeon General Richard H. Carmona. Rockville, MD.

[107] Centers for Disease Control and Prevention Task Force on Community Preventive Services. (2005). Recommendations to reduce violence through early childhood home visitation, therapeutic foster care, and firearm laws. *Journal of Preventive Medicine*, 28(2S1), 6-10.

[108] Wilcox, H.C., S.G. Kellam, C.H. Hendricks Brown, J.M. Poduska, N.S. Ialong, W. Wang, and J.C. Anthony. (2008). The impact of two universal randomized first-and second-grade classroom interventions on young adult suicide ideation and attempts. *Drug and Alcohol Dependence*, 95S, S60-S73.

[109] Eisenberg ME, Resnick MD. (2006). Suicidality among gay, lesbian and bisexual youth: the role of protective factors. *Journal of Adolescent Health*, 39, 662–668.

[110] California Department of Education. (2005). *Youth suicide prevention guidelines for California schools*. Learning Support and Partnerships Division, Sacramento, CA.

[111] National Conference of State Legislatures. (2007). *Screening and entry into mental health treatment: Balancing help for the individual and community*. Retrieved October 2, 2007 from National Conference of State Legislatures Web site: http://www.ncsl.org

[112] Project Link Program Profile. Compiled by the Consensus Project, a Council of State Governments Justice Center Project. Retrieved July 28, 2008 from Consensus Project Web site: http://consensusproject.org/programs/one?program_id=148

[113] California Department of Corrections and Rehabilitation. (2006). California prisoners and parolees: Summary statistics on adult felon prisoners and parolees, civil narcotics addicts and outpatients, and other populations. Retrieved from California Department of Corrections and Rehabilitation Web site: http://www.cdcr.ca.gov/Reports_Research/Offender_Information_Services_Branch/Annual/CalPris/CALPRISd2006.pdf

[114] American Psychiatric Association. (2008). Partnership launches "Employer Innovations Online". *Mental Health Works*, First Quarter, 2008, p. 3.

[115] Substance Abuse and Mental Health Services Administration. (2007). Employers Honored for Behavioral Health Services. *SAMHSA News*, November/December 2007, Vol.15. Rockville, MD.

[116] U.S. Dept. of the Army. (2006). *Mental Health Advisory team IV (MHAT IV), Operation Iraqi Freedom, 05 07, Final Report*. Office of the Surgeon, Multinational Force-Iraq and Office of the Surgeon General, U.S. Army Medical Command. November 17, 2006, pp. 66-73.

[117] U.S. Dept. of Health and Human Services. (2002). Air Force Suicide Prevention Program: A population-based, community approach. *Best Practice Initiative*. Rockville, MD.

[118] Knox, K.L., D.A. Litts, G.W. Talcott, J.C. Feig, and E.D. Caine. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: cohort study. *British Medical Journal*, 327(13), December 2003, 1-5.

[119] Knox, K.L., Y. Conwell, and E.D. Caine. (2004). If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health*, 95(1), 37-46.

[120] Suicide Prevention Resource Center. (2004). *Promoting Mental Health and Preventing Suicide in College and University Settings*. Retrieved July 28, 2008 from Suicide Prevention Resource Center Web site: www.sprc.org/library/college_sp_whitepaper.pdf

[121] Suicide Prevention Resource Center. (n.d.). Retrieved July 30, 2008 from Suicide Prevention Resource Center Web site: http://library.sprc.org/browse.php?catid=33

[122] Feldman, M.D., P. Franks, P.R. Duberstein, S. Vannoy, E. Epstein, and R.L. Kravitz. (2007). Let's not talk about it: Suicide inquiry in primary care. *Annals of Family Medicine*, 5(5), September-October 2007, 412-418.

[123] Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., & Haas, et al. (2005). Suicide prevention strategies: A systematic review. *Journal of the American Medical Association*, 294(16), 2064- 2074.

[124] Dupont, Randolph and Sam Cochran. (2000). Police response to mental health emergencies – Barriers to change. *Journal of the American Academy of Psychiatry and the Law*, 28, 338.

[125] Reuland, M. (2004). *A guide to implementing police-based diversion programs for people with mental illness*. Technical Assistance and Policy Analysis Center for Jail Diversion, Delmar, N.Y.

[126] Beautrais, A. (2007). The contribution to suicide prevention of restricting access to methods and sites. *Crisis*. 28(1), 1-3.

[127] Miller, M., S.J. Lippman, D. Azrael, and D. Hemenway. (2007). Household firearm ownership and rates of suicide across the 50 United States. *Journal of Trauma-Injury Infection & Critical Care*. 62(4), 1029-1035.

[128] Grossman, D.C., B.A. Mueller, C. Riedy, M.D. Dowd, A. Villaveces, et al. (2005). Gun storage practices and risk of youth suicide and firearm injuries. *Journal of the American Medical Association*, 293(6), 707-714.

[129] Kapusta, N.D., E. Etzersdorfer, C. Krall, and G. Sonneck. (2007). Firearm legislation reform in the European Union: Impact on firearm availability, firearm suicide and homicide rates in Austria. *British Journal of Psychiatry*. 194, 253-257.

[130] Webster, D.W., J.S. Vernick, A.M. Zeoli, and J.A. Manganello. (2004). Association Between Youth-Focused Firearm Laws and Youth Suicides. *Journal of the American Medical Association*, 292, 594-601.

[131] Beautrais, A. (2007). Suicide by jumping: A review of research and prevention strategies. *Crisis*, 28(1), 58-63.

[132] Seiden, R.H. (1978). Where are they now? A follow-up study of suicide attempters from the Golden Gate Bridge. *Suicide and Life Threatening Behavior*, 8(4), Winter 1978, 1-13.

[133] Marin County Coroner's Office. (2007). *A Ten-year report: Golden Gate Bridge suicide demographics*. Retrieved from Bridge Rail Foundation Web site: http://www.bridgerail.org/pdf/GG%20Bridge%2010-Yr%20Rprt.pdf

[134] Golden Gate Bridge Physical Suicide Deterrent System Project. Retrieved July 28, 2008 from Physical Suicide Deterrent System Project Web site: http://www.ggbsuicidebarrier.org/

[135] Jamison, K.R. (2006). The many stigmas of mental illness. *Lancet*, 367, 533-34.

[136] National Mental Health Awareness Campaign. (2006). Retrieved from National Mental Health Awareness Campaign Web site: http://www.nostigma.org

[137] California Department of Health Services, Tobacco Control Section. (2006). *California tobacco control update, 2006*. Sacramento, CA.

[138] Hassan, R. (1995). Effects of newspaper stories on the incidence of suicide in Australia: A research note. *Australian and New Zealand Journal of Psychiatry*, 29, 480-483.

[139] Phillips, D.P., Lesyna, K., and Paight, D.J. (1992). Suicide and the media. In R.W. Maris, A.L. Nerman, J.T. Maltsberger et al. (Eds.) *Assessment and Prediction of Suicide* (pp. 499-519). New York: The Guildford Press.

[140] Pirkis, J., Burgess, P., Blood, W., & Francis, C. (2007). The newsworthiness of suicide. *Suicide and Life-Threatening Behavior*, 37(3), 278-283.

[141] American Association of Suicidology. (n.d.) *Recommendations for Media*. Retrieved January 7, 2008 from American Association of Suicidology Web site: http://www.suicidology.org/associations/1045/files/MediaRecommendations.pdf

[142] Durfee, M., D.T. Durfee, and M.P. West. (2002). Child fatality review: An international movement. *Child Abuse and Neglect*, 26, 619-636.

[143] Schecter, W.P., C. Klassen, p. O'Connor, M. Potts, and H. Ochitill. (2005). Suicide: The unmet challenge of the trauma system. *Archives of Surgery*, 140(9), September 2005.

[144] California Department of Justice. (2005). *Outlook: Death in Custody, California*. Criminal Justice Statistics Centers, May 2005.

[145] Mrazek PJ and Haggerty RJ 1994, Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research, National Academy Press, Washington, D.C.

[146] Commonwealth Department of Health and Aged Care 2000, Promotion, *Prevention and Early Intervention for Mental Health—A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, Publications Production Unit.

OMB No. 0930-0168 Approved: 07/19/2011 Expires: 07/31/2014 Page 218 of 220

Copies of The California Strategic Plan on Suicide Prevention and an Executive Summary of the Plan are available for download from the California Department of Mental Health web site at ***www.dmh.ca.gov***. Hard copies can be requested by contacting the Office of Suicide Prevention via postal mail, e-mail, or telephone.

Office of Suicide Prevention
Prevention and Early Intervention Section
California Department of Mental Health
1600 9th Street, Room 150
Sacramento, CA 95814
suicideprevention@dmh.ca.gov
(916) 651-1178

CALIFORNIA DEPARTMENT OF
Mental Health